Sleep Lab Changes

Please note: As of July 1, 2010, OHIP will permit only 1 Diagnostic (first time) sleep study per patient, per lifetime, within the province of Ontario.

Repeat Diagnostic studies can only be ordered by Sleep Specialists after seeing patients in Consult.

OHIP will only permit 1 Therapeutic sleep study (with CPAP or positional Therapy or Oral Appliance), every 24 months, within the province of Ontario, unless prior authorization is arranged.

Excess studies will be charged to the patient unless prior authorization has been arranged.

If you have had a previous sleep study, in the province of Ontario, your scheduled Sleep study may not be able to proceed as scheduled. Please contact the Sleep Lab immediately to determine your eligibility @ 905-813-1100 x5295.

If you have questions or concerns please contact the Sleep Lab at the above number as well.

Thank you,
The Credit Valley Hospital Sleep Lab

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SLEEP LABORATORY

PATIENT INFORMATION

DATE: ____________________

NAME: ____

ADDRESS:

____

____

TELEPHONE: (HOME) ___________________________ (WORK) ________________________

Dr. ____ has arranged for you

to have a sleep study. Your overnight study has been scheduled for:

____at___________________P.M.

*****IF YOU HAVE EVER HAD A PREVIOUS SLEEP STUDY, ANYWHERE IN THE PROVINCE OF ONTARIO, PLEASE CONTACT THE SLEEP LAB IMMEDIATELY TO DETERMINE WHETHER YOU'RE SLEEP STUDY CAN PROCEED AS SCHEDULED.**

Please arrive 15 minutes prior to your scheduled appointment time.

It is very important to confirm your appointment 1 week before the study by calling 905-813-1100. ext.5295

WE REQUIRE TWO BUSINESS DAYS NOTICE FOR ANY CANCELLATIONS OR REBOOKINGS

A HOSPITAL BEDROOM HAS BEEN RESERVED ESPECIALLY FOR YOU. IF YOU DO NOT KEEP YOUR APPOINTMENT, THE ROOM IS EMPTY FOR THAT NIGHT. THERE IS A LONG LIST OF PEOPLE WAITING TO BE SEEN IN THIS BUSY AND COSTLY CLINIC AND WE THEREFORE ASK THAT YOU PLEASE CONFINE CANCELLATIONS TO ILLNESS OR PERSONAL EMERGENCIES ONLY.

PARKING IS AVAILABLE IN THE PARKING GARAGE ACROSS FROM THE MAIN ENTRANCE. PLEASE BE AWARE THAT THERE IS A PARKING FEE TO BE PAID ON YOUR WAY OUT.

The Sleep Laboratory is located within the **Cardiopulmonary Department** in the hospital. To find the Sleep Lab please enter the newest part of the hospital through the main front revolving door. The Cardiopulmonary Department is located on the third level at the top of the main staircase to your right. There are elevators in the main lobby as well that will take you to Level 3. Please follow the signage to the Sleep Lab. There is a phone located at the front reception desk. Please dial extension **6060** or **6067** to contact one of the technologists.

Please enquire at the Information Desk in the lobby if you are not familiar with the hospital.

PLEASE REMEMBER to bring your diaries, questionnaires and all of your usual medications with you to take as you would at home. If you are being treated with nasal CPAP at home, bring ALL of your equipment with you UNLESS you are told otherwise.

IT IS MANDATORY THAT YOUR HEALTH CARD BE PRESENTED WHEN ARRIVING FOR YOUR STUDY.

Please read and follow the enclosed sheet of instructions.

We are anxious to make your stay in the Sleep Laboratory as pleasant as possible. Thank you for your cooperation.

The telephone number for the Sleep Laboratory is (905) 813 - 1100, extension 6060.

Please call this number *only if you are canceling on the night of the sleep study* or before the next regular working day.

What is a Sleep Study?

A clinical sleep study consists of overnight observation and monitoring of patients while they sleep. This is done in a specialized sleep lab, like the one you will be attending at The Credit Valley Hospital.

When you arrive at the Sleep Laboratory, you will be greeted by the technologist who will explain the procedures for the night. In brief, electrodes, (thin wires), will be attached to the surface of the skin with tape and a slight amount of glue to monitor various functions during the night. There is no permanent discomfort and virtually everyone is able to sleep without difficulty in their usual manner. You will be in a private room to sleep but the washroom facilities are shared. You will be under continuous observation with a video monitor. Please read the following recommendations and observe them as closely as possible.

1. Do not drink any alcoholic beverages for 12 hours before you come to the hospital.

2. Please do not consume any caffeine after 6 p.m. on the night of the study unless this is your usual pattern and it does NOT prevent you from sleeping. This includes all coffee, tea, chocolate, colas etc.

3. Please call the sleep lab if your health changes or you develop a bad cold, influenza or other health problems just prior to your sleep study.

4. Do not bring large sums of money or unnecessary jewelry with you to the hospital. *The Credit Valley Hospital assumes no responsibility for loss of personal items.*

5. Please bring a comfortable robe and pajamas, as well as your own personal hygiene items to the hospital. Nightgowns (for ladies) are NOT optimal. You may bring a favourite pillow if desired.

6. It is recommended that you wash your hair during the day or prior to the sleep study.

7. Bring all of your medications with you and take them as usual, unless you are advised otherwise. If you are on NCPAP, bring your equipment with you to the sleep study.

8. If you are diabetic, please bring a snack with you in case of hypoglycemic episodes. A kitchen is NOT available in the sleep lab.

9. Do not nap during the day of your sleep study.

10. Please complete the enclosed sleep diary for the 5-6 days before your study.

11. You will be awakened between 5:30 and 6:00 in the morning. PLEASE ADVISE THE STAFF if you need to be awakened earlier. Shower facilities are **NOT** available. Breakfast Is NOT provided.

12. Parking is available in the hospital parking lot directly in front of the main hospital entrance.

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SLEEP QUESTIONNAIRE

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR SLEEPING HABITS FOR THE PAST TWO WEEKS

NAME: ____ DATE: ____________________________

1) On weekdays what time do you usually turn out the lights to go to sleep? ___________ On weekends? ____________

2) Are you a shiftworker? Y N

3) How long does it usually take you to fall asleep? ____________________________

4) Do you take sleeping pills? Y N Occasionally

5) Once asleep, how many times do you awaken during the night? ____________________________

6) Why do you awaken? ____

7) Do you usually have problems returning to sleep? Y N

8) What position do you usually sleep in? Back Side Stomach

9) What time do you arise in the mornings on weekdays? __________________

10) Do you need an alarm? Y N Occasionally

11) What time do you arise in the mornings on weekends? ____________________

12) How many hours of sleep do you average nightly on weekdays? ___________________

13) How do you feel when you awaken on weekdays? ____

14) How do you feel when you awaken on weekends? ____

15) If not completey rested when you awaken, how long after you arise does it take before you feel better?

____

16) How frequently during the day do you feel tired enough to fall asleep? __________________________________

17) Do you nap? _______________________ If so, how long? ______________

18) Do you doze off while reading or watching TV regularly? Y N

SLEEP QUESTIONNAIRE

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR SLEEPING HABITS FOR THE PAST TWO WEEKS

NAME: ______________________________ DATE: ______________________

19) Have you had problems with sleepiness while driving usual distances? Y N

20) How many caffeinated beverages do you take every day? ____________

21) How many drinks of alcohol of any type have you had over the past TWO weeks? ______________

22) How many pounds do you weigh? __________ Height? ________

23) While asleep, have you ever felt unable to move? Y N

24) Had strange dreams or hallucinations at sleep onset? Y N

25) Had frequent repeated leg twitches? Y N

26) Had attacks of sudden muscle weakness or falling? Y N

27) Do you snore very loudly? __________ Stop breathing and gasp? __________

28) How many hours a night do you use your NCPAP (if you are on this therapy?) __________

29) Have you previously been diagnosed with?

Sleep Apnea Y N

Fibromyalgia Y N

Chronic Fatigue Syndrome Y N

Narcolepsy Y N

Depression/Anxiety Y N

Restless Legs Syndrome Y N

Periodic Leg Movements While Asleep Y N

Please list all of your current medications:

____

____

____

____

____

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THE EPWORTH SLEEPINESS SCALE

NAME: ____

TODAY'S DATE: ______________________________

YOUR AGE: (years): ____________

YOUR SEX (male = M; female = F): _________

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the ***most appropriate*** number for each situation.

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

SITUATION	**CHANCE OF DOZING**			
Sitting or Reading	0	1	2	3
Watching T.V.	0	1	2	3
Sitting, inactive in a public place (e.g. theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic (as the driver)	0	1	2	3

SLEEP LABORATORY PATIENT DIARY

Instructions: Leave the diary near your bedside and fill in the diary every morning and evening.
Fill in time of Lights Out, Total Sleep Time & Total Time in Bed.

Activities Symbols

- A Each alcoholic drink
- C Each caffienated drink (coffee, tea, cola, chocolate)
- P Each sleeping pill or tranquilizer
- M Meal
- S Snack
- X Exercise
- T Toilet Use
- N Noises that disturb your sleep
- W Wake-up Alarm (if used)

Sleep Time Symbols

- v Indicate with the down arrow each time you get into bed.
- ^ Indicate with the up arrow each time you get out of bed.
- | Indicate with a vertical line when you fall asleep and when you awake then join the lines to indicte a period of sleep.

Example	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm
Activity		ACM		A	A	SX		T					T		W	CM		CS			CM		AAS	
Sleep Time						v		^ v					^ v		| |	|						v	^	

Lights out at 10:45 am/pm Date: Wednesday Jan 21/04 Total Sleep TIme: 9 1/2 hrs Total Time in Bed: 11 hrs

Day 1	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm
Activity																								
Sleep Time																								

Lights out at ________ am/pm Date: ________ Total Sleep TIme: ________ hrs Total Time in Bed: ________ hrs

Day 2	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm
Activity																								
Sleep Time																								

Lights out at ________ am/pm Date: ________ Total Sleep TIme: ________ hrs Total Time in Bed: ________ hrs

Day 3	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm
Activity																								
Sleep Time																								

Lights out at ________ am/pm Date: ________ Total Sleep TIme: ________ hrs Total Time in Bed: ________ hrs

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SLEEP LABORATORY PATIENT DIARY

Day 4	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm
Activity																								
Sleep Time																								

Lights out at ________am/pm Date: ____________ Total Sleep TIme: ________ hrs Total Time in Bed: ________ hrs

Day 5	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm
Activity																								
Sleep Time																								

Lights out at ________ am/pm Date: ____________ Total Sleep TIme: ________ hrs Total Time in Bed: ________ hrs

Day 6	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm
Activity																								
Sleep Time																								

Lights out at ________ am/pm Date: ____________ Total Sleep TIme: ________ hrs Total Time in Bed: ________ hrs

Day 7	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm
Activity																								
Sleep Time																								

Lights out at ________am/pm Date: ____________ Total Sleep TIme: ________ hrs Total Time in Bed: ________ hrs