

Please mail or fax the medication page prior to your sleep study to 785-210-3443 or 785-210-3442. Or, it can be e-mailed to agarcia@gchks.org. If that is not possible be sure to bring your medication list with you the night of your sleep study.

Geary Community Hospital
1102 St. Mary's Road
Junction City, KS 66441

Dear:

You are scheduled to have a sleep study on _____. You will need to report to the hospital by 8-8:30 pm at the emergency room registration.

Please read the enclosed information and answer the questionnaires. Be as accurate as possible, as this information is valuable to the doctor. You will need to bring these questionnaires with you on the day of your test.

Any question or comments can be made to Geary Community Hospital at 785-210-3389 between 8:00 am and 5:00 pm. After 5:00 pm, please call 238-4131 and have the operator page the Respiratory Technician.

Thank you,
Geary Community Hospital Sleep Lab
Phone: 785-210-3394 Fax: 785-210-3443

***Geary Community Hospital
Sleep Lab
Medication List***

Name: _____ Date: _____

List any medications you take including, prescription, over-the-counter, vitamins and herbals. **Please print clearly.**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

Drug allergies (include type of reaction):

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PATIENT INFORMATION

When you arrived at Geary Community Hospital, please park in the Emergency Room lot (the North end of the hospital). Enter the Emergency Room entrance. Go to Registration desk and register. Give your name to the clerk and let them know that you are here for a sleep study. When done registering wait there until the sleep tech comes to get you.

Congratulations! You have taken the first steps to better sleep.

This information is provided to help answer some of your questions and make your stay with us a little easier. If you anticipate being later or you cannot make your overnight appointment, please call us at (785) 238-4131 ext. 4229 between 8 am and 5 pm) at your earliest opportunity. If you have excessive daytime sleepiness, have someone drive you to and from the hospital.

What is a Polysomnogram?

A Polysomnogram is a sleep study. It measures what happens when you are asleep. A minimum of 14 different channels are observed. The information that is gathered, tell us what happens when you are asleep. Breath by breath.

What is measured?

1. Brain waves (about 12 – 14 wires on your head)
2. Heart beats (2 wires on your chest)
3. Eye movement (1 wire next to each eye)
4. Muscle Tension and movement
5. Leg movements (2 wires on each leg)
6. Breathing (sensor belts around your chest and abdomen)
7. Oxygen level (a small sensor on a finger)
8. Airflow (a sensor under your nose).

Does any of this hurt?

No. There is an abrasive cream used in very small areas of the skin, but it generally causes very little irritation.

How do I sleep with all of this stuff on?

The majority of people have no problems falling asleep. In some cases, a physician may ask you to take a mild sleeping pill.

Will I be able to get up to use the restroom?

Yes, getting up is no problem; the technologist will show you what to do.

What should I bring with me?

1. You will need comfortable sleep clothes. (Pajamas, gym short, tee shirt or a night gown)
2. Toiletries; toothbrush/paste, shampoo, and comb or brush.
3. Your pillow, if you wish. (Some people sleep better with their own pillow)
4. The clothes you wish to wear the next day. (Many people go straight to work from here)
5. Reading material, if you choose
6. Any medication you are taking.
7. Completed sleep questionnaire.

Are there any special things I should do?

Yes, there are only a few requirements.

1. The day of your test, do not eat or drink anything with caffeine in it after noon.
2. Do not consume any alcohol after noon.
3. Do not take a nap.
4. Do not use any hair oils or sprays.
5. Remove finger nail polish from one finger on each hand.
6. Take only the medications approved by the doctor.

What time do I go to bed and get up?

Bedtime is between 10 –11 p.m. and we will be getting you up at 6 a.m. (we will get you up earlier if necessary) Testing requires a minimum of 6 hours of sleep time.

May I bring a snack?

Yes, you may bring a light snack if you wish. Please avoid anything with caffeine like chocolate, or sodas.

We will provide:

A private room with a T.V., restroom and shower.

When do I find out the results?

It usually takes between one and two weeks for the results to be sent to your doctor.

Geary Community Hospital Sleep Lab

Personal Questionnaire

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Work) _____ (Home) _____

Occupation: _____ # of years: _____

Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed

Birthdate: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Insurance Co. _____ Policy # _____

Has your weight changed recently: _____ Yes _____ No

If yes, by how much? _____ Gained _____ Lost

Have you had a sleep study before _____ Yes _____ No

If you answered yes, how long ago was the study-completed? _____

Where? _____

Are you currently using a CPAP or BIPAP at home? _____ Yes _____ No

If yes, what pressure are your currently using? _____ cm

Do you have a humidifier with your unit? _____ Yes _____ No

Are you currently using oxygen at home? _____ Yes _____ No

If yes, how many liters per minute? _____ liters per minute

Do you use oxygen? _____ only at night _____ also during the day.

Name: _____

Medical history:

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> GERD | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Depression | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Stroke(s) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Seizure Disorder | Other: _____ |

Comments:

Surgical History:

- | | | | |
|--|--------------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Appendix | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sinus | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Carotid | <input type="checkbox"/> Heart | <input type="checkbox"/> Other: _____ | |

Alcohol use: Yes No Type/quantity/frequency: _____

Illicit drug use: Yes No Type/quantity/frequency: _____

Caffeine use: Yes No Type/quantity/frequency: _____

House pets: Yes No Type(s): _____

Tobacco history: Current Former Never

Type(s): _____ Quantity/frequency: _____

Quit date: _____ Total years used: _____

Methods used to quit: _____

Exposed to secondhand smoke: Yes No Total years: _____

Exposed to dust, fumes, chemicals or asbestos: Yes No Total years: _____

Describe: _____

Name: _____ Date: _____

Weight _____ Height _____ Neck measurement _____

The Epworth Sleepiness Scale

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

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing
-----------	------------------

Sitting and reading _____

Watching TV _____

Sitting inactive in a public place (theater, meeting) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon when circumstances permit _____

Sitting and talking to someone _____

Sitting quietly after lunch without alcohol _____

In a car, while stopped for a few minutes in traffic _____

Total Score _____

Geary Community Hospital Sleep Lab

Questions about your sleep and wake behavior. Please state in your own words the reason you or your doctor contacted the Geary Community Hospital Sleep Lab.

When falling asleep or trying to fall asleep, how often do you: (Check one Box for each statement).

About Falling Asleep

	Never	Sometimes	Often
1. Have thoughts racing through your mind?	_____	_____	_____
2. Feel sad or depressed?	_____	_____	_____
3. Have anxiety (worry)?	_____	_____	_____
4. Feel muscular tension?	_____	_____	_____
5. Feel afraid of not being able to fall asleep?	_____	_____	_____
6. Feel unable to move?	_____	_____	_____
7. Have creeping, crawling, aching or twitching in your legs?	_____	_____	_____
8. Have vivid, dream like scenes even though you know you are not totally asleep?	_____	_____	_____
9. Have any kind of pain or discomfort?	_____	_____	_____
10. Feel afraid of the dark or anything else?	_____	_____	_____
11. Suddenly becomes aware or alert?	_____	_____	_____
12. Feel afraid you will not return to sleep after awaking?	_____	_____	_____

	Never	Sometimes	Often
13. Sleep with someone else in your room?	_____	_____	_____
14. Sleep with someone else in your bed?	_____	_____	_____
15. Have disturbed sleep?	_____	_____	_____
16. Get up at night to attend to your children or something else?	_____	_____	_____
17. Snore loudly?	_____	_____	_____
18. Feel your heart pounding during the night?	_____	_____	_____
19. Walk in your sleep?	_____	_____	_____
20. Fall out of bed while asleep?	_____	_____	_____
21. Wake up screaming, violent or confused?	_____	_____	_____
22. Have unusual movements while asleep?	_____	_____	_____
23. Wet the bed?	_____	_____	_____
24. Have dreams?	_____	_____	_____
25. Grind your teeth?	_____	_____	_____

My Sleep is frequently disturbed by: (Check all that are true).

- | | |
|---|--------------------------------------|
| _____ Heat | _____ Choking |
| _____ Cold | _____ Indigestion (Gas or Heartburn) |
| _____ Light | _____ Hunger |
| _____ Noise | _____ Thirst |
| _____ Noise or movement from your
bed partner | _____ Need to urinate |
| _____ Asthma | _____ Chest Pain |
| _____ Coughing | _____ Frightening dreams |
| _____ Creeping, crawling or aching feelings in your legs (as if you have to move
them) | |

About Waking Up

How often do you? Check one box of each statement).

- | | Never | Sometimes | Often |
|---|-------|-----------|-------|
| 1. Depend on an alarm clock to wake up? | _____ | _____ | _____ |
| 2. "Sleep in" in the morning (more than one hour) past your usual wake time? | _____ | _____ | _____ |
| 3. Have a very hard time waking up? | _____ | _____ | _____ |
| 4. Feel unable to move when waking up? | _____ | _____ | _____ |
| 5. Have dream like images when waking up even though you know you are not asleep? | _____ | _____ | _____ |

