Commonwealth Sleep Center

4660 Kenmore Ave, Suite 900, Alexandria, VA 22302
Phone: 571-261-9877 | Fax: 571-248-0583
CONTACT US | www.commonwealthsleepcenter.com

SLEEP STUDY REGISTRATION FORM

PATIENT INFORMATION

TODAY DATE: ___/____/____

First Name: _____Last Name _____Middle_____

Date of Birth: ___/____/_____ Sex: ☐ Male / ☐ Female / ☐ Transgender Age: _____ Social Security: #_____/____/_____

Home Address: _____City: _____ State: _____Zip: _____

Home Phone #: _____-_____-_____ Work Phone #: _____-_____-_____ Mobile Phone #: _____-_____-_____

Email Address: _____ Marital Status: ☐ Single : ☐ Married : ☐ Divorced :☐ Widow

Emergency Contact Name: _____ Phone: _____Relationship: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____/_____/_____

Occupation: _____ Employer: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: ___/____/_____

Secondary Insurance Information

Policy #: _____ Group #: _____

REFERRING PROVIDER INFORMATION

Referring Physician Name: _____

Physician's Address: _____City: _____ State: _____Zip: _____

Phone Number #: _____-_____-_____ Fax #: _____-_____-_____

Family Physician (If different from Referring): _____

Family Physician's Name: _____

Physician's Address: _____City: _____ State: _____Zip: _____

Phone Number #: _____-_____-_____ Fax #: _____-_____-_____

SCREENING QUESTIONS - SLEEP HISTORY

Patient Name: _____ Date of Birth: ____/____/_____

Height: _____ (Inch) Weight: _____ (LB) Neck size: _____(Inch) BMI _____

Have you ever had a sleep study? ☐ Yes ☐ No

If YES, please provide us the sleep study reports.

Are you currently using CPAP / BiPAP? ☐ Yes ☐ No

If YES, SKIP the section **#1 & #2, Go to section #3.**

What is your primary sleep problem?

_____

_____

_____

How long have you had that problem?

_____

_____

_____

What time do you usually go to bed and getup?	Weekdays	Go to bed	AM	PM
		Get up	AM	PM
	Weekends	Go to bed	AM	PM
		Get up	AM	PM

How many nights a week do you get:			
8+ hours of sleep?	7 hours of sleep?	6 hours of sleep?	5 or less hours of sleep?
nights	nights	nights	nights
How often do you nap?	/ week	For How Long?	/ min
Do you wake up feeling refreshed? ☐ Yes ☐ No Do you have excessive daytime sleepiness? ☐ Yes ☐ No			

Section 1: Screening questions for SLEEP APNEA:	
Do others complain about your snoring?	☐ YES ☐ NO
Has anyone witnessed you during an apneic event? (Have you period when there is no snoring followed by a loud snort to a body jerk?) If so, how often?	☐ YES ☐ NO
Do you awaken from sleep short of breath or with a feeling of being choked?	☐ YES ☐ NO
Do you have nighttime sweating?	☐ YES ☐ NO
Do you have morning headaches?	☐ YES ☐ NO
Do you have multiple nocturnal awakenings? What wakes up, when, how many times a night?	☐ YES ☐ NO
Weight gain or loss over the past 12 months?	☐ YES ☐ NO

Section 2: EPWORTH SLEEP SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
Use the following scale and indicate 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	Change of Dozing
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place (ie., school or movie)	
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	
In a car, while stopped for a few minutes in traffic	
Total (Range 0-24):	

Section 3: Screening questions for NARCOLEPSY

Includes the uncomfortable urge to sleep during the day, especially during emotional events (feeling happy, sad, or mad)?

Do you feel your knees buckle, arms feel weak, or jaw drop with strong emotions? (Cataplexy)	☐ YES ☐ NO
Do you experience vivid dream-like episodes or scenes upon awakening or falling asleep that you can't tell whether they are real or not? (Hypnagogic Hallucinations)	☐ YES ☐ NO
Do you feel paralyzed when waking or falling asleep? (Sleep Paralysis)	☐ YES ☐ NO
Do you fall asleep at inappropriate times or experience sleep attacks?	☐ YES ☐ NO

Section 4: Screening questions for RESTLESS LEG MOVEMENTS SYNDROME / PERIODIC LEG OF SLEEP	
Do you have leg cramps at bedtime?	☐ YES ☐ NO
Do you experience crawling and achy feelings in your legs during the day or night which makes you want to move them or	☐ YES ☐ NO
Do you notice that these feelings in your legs are worse at night time?	☐ YES ☐ NO
Do the symptoms occur with (or are worsened by) rest?	☐ YES ☐ NO
Do you have relief with movement?	☐ YES ☐ NO
Do you wake yourself with body jerks (arms or legs)?	☐ YES ☐ NO
Have you been told that your legs or arms move every 20 seconds or so during the night?	☐ YES ☐ NO
Are your bedcovers in total disarray in the morning?	☐ YES ☐ NO

Section 5: Screening questions for PARASOMNIAS (or things that go "bump" in the night including REM behavior disorder and include disorders of sleep walking or sleep talking)	
Do you have nightmares?	☐ YES ☐ NO
Do you often move violently during your sleep while dreaming, and sometimes even hurt yourself or your partner by accident or fall out of bed?	☐ YES ☐ NO
Have you been told you sleepwalk?	☐ YES ☐ NO
Have you been told you arouse from sleep totally confused or are inconsolable?	☐ YES ☐ NO
Have you awakened feeling panicked with your beating uncontrollably?	☐ YES ☐ NO
Do you have a history of seizures?	☐ YES ☐ NO

Section 6: Screening questions for INSOMNIA	
Check if you are currently diagnosed with: ☐ Depression ☐ Anxiety	
Do you routinely require more than 30 minutes to fall asleep?	☐ YES ☐ NO
Do you wake up several times during the night and can't get back to sleep? What causes you to wake up? _____	☐ YES ☐ NO
Do you often wake up one or two before scheduled wake time and can't get back to sleep?	☐ YES ☐ NO
Do you have thoughts racing through your mind while trying to fall asleep?	☐ YES ☐ NO
Do you read, watch TV, or use a laptop in bed?	☐ YES ☐ NO
Do you deliberately sleep less in order to do other things? If yes, please specify:_____ nights/week _____ hrs/night	☐ YES ☐ NO
When you try to sleep, does worrying or problem solving often keep you awake?	☐ YES ☐ NO
Do you often lose sleep because your bed partner disturbs you at night?	☐ YES ☐ NO

Section 7: Screening questions for CIRCADIAN RHYTHM DISORDER	
Do you have trouble waking up in the morning and would rather stay up later (ie. Sleep at 2-3AM and wake up at noon?) (Delayed Sleep Phase - more common in adolescents)	☐YES ☐ NO
Do you have to go to bed at 8PM only to find out that you wake up at 3AM? (Advanced Phase Syndrome - more common in elderly)	☐YES ☐ NO
Does your job require you to work different shifts?	☐YES ☐ NO

Section 8: Screening questions for BRUXISM	
Do you have morning jaw pain?	☐ YES ☐ NO
Do you grind your teeth during sleep?	☐ YES ☐ NO

Section 9: Other - WEIGHT LOSS AND WELLNESS	
Are you concerned about your weight?	☐ YES ☐ NO
Have you had significant weight loss? How much and over what period of time?	☐ YES ☐ NO
Have you had significant weight gain? How much and over what period of time? _____	☐ YES ☐ NO
Section 10: Other - NASAL OR BREATHING OBSTRUCTION	
Do you have problems breathing through your nose especially at night?	☐ YES ☐ NO
Does the nasal blockage come and go?	☐ YES ☐ NO
Is your nasal blockage constant?	☐ YES ☐ NO
Is one side always worse than the other?	☐ YES ☐ NO

Section 11: SOCIAL HISTORY
Caffeine consumption: How much per day? _____ cups/day When do you typically consume your last serving of coffee? _____ AM /PM
Alcohol consumption: Type of drink: _____ How many times? _____ / wk How many hours before bed? _____
Smoking habits: How many packs per day? _____ Over how many years? _____

Section 12: FAMILY HISTORY		
Have any members of your family (blood kin) had: Heart disease	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Have any immediate family members been diagnosed with or treated for a sleep disorder? If yes, please explain: _____ _____	☐ YES	☐ NO

Section 13: ALLERGIES
☐ No Known Allergies ☐ Other

Section 14: PERSONAL MEDICAL HISTORY	
Arrythmia	☐ YES ☐ NO
Asthma	☐ YES ☐ NO
Congestive Heart Failure	☐ YES ☐ NO
COPD	☐ YES ☐ NO
Coronary Artery Disease	☐ YES ☐ NO
Dementia	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO
Heart Attack	☐ YES ☐ NO
Hypertension	☐ YES ☐ NO
Migraine	☐ YES ☐ NO
Neuromuscular Impairment	☐ YES ☐ NO
Seizure	☐ YES ☐ NO
Stroke	☐ YES ☐ NO
Other medical history: _____ _____	

Section 15: SURGICAL HISTORY Please choose any Head / Nose / Throat / Surgeries	
Tonsillectomy	☐ YES ☐ NO
Adenoidectomy	☐ YES ☐ NO
Sinuplasty	☐ YES ☐ NO
Uvulopalatopharyngoplasty (UPPP)	☐ YES ☐ NO
Septoplasty	☐ YES ☐ NO
Any other Major surgical history: _____ _____	

Section 16: MEDICATION LIST			
Medication	Dose	How often	Reason

Patient/Guardian Signature: _____ **Date:** _____

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Commonwealth Sleep Center office. I understand that if I have questions regarding this notice, I may contact the Privacy Officer at the above address.

I indicate below the names of the any person (s) to whom I would like Commonwealth Sleep Center office to allow disclosure of Individually Identifiable Health Information (IIHI), e.g. labs, x-rays, health conditions, prognosis and diagnosis, appointments and prescription information.

NAME: _____ RELATIONSHIP: _____

ALLOWED DISCLOSURES_____ (Limited or All)

[PLEASE SPECIFY TYPE OF INFORMATION THAT MAY IF DISCLOSED, YOU MAY INDICATE "ALL" IF APPLICABLE].

PLEASE PROVIDE A PHONE NUMBER _____

THAT YOU WISH TO BE CONTACTED BY OUR OFFICE ABOUT APPOINTMENTS AND TEST RESULTS

Phone Signature of Patient or Legal Guardian: _____

First Name of legal Guardian: Patient's Name: _____

FOR OFFICE USE ONLY

Date Received: _____

Date:_____

Patient's Date of Birth: _____

Received By: _____

SLEEP STUDY INSTRUCTIONS

What to bring:

- Photo ID (Driver's license)
- Insurance Card (s)
- Bed clothes. Bring something comfortable to sleep in, including a bathrobe and slippers. Keep in mind that both male and female technicians may monitor your sleep study.
- Toiletries. Bring whatever you need to spend night away from home (tooth brush, tooth paste, soap, etc.).
- All your medications.

Before your study:

- Do not take any naps the day of your sleep study if possible.
- Do not consume any alcohol or caffeine after 12pm (noon) the day of your sleep study.
- Take a shower prior to arriving for your sleep study and do not apply any hair care products (hair gel, hair spray, oils).
- Do not wear make-up or use heavy creams on your face the night of the study.

What to expect:

- The sleep study is a combination of several diagnostics tests all recorded simultaneously during sleep.
- Brain wave activity (EEG) will be recorded by attaching electrodes with adhesives and paste around the head.
- Additional sensors are placed on your chest, legs, finger and below your nose.
- All sensors are painless and will still allow you to sleep in any position you want.
- You will also be able to move around and get out of bed with the sensors (i.e. – to use the bathroom).
- The sleep technician will greet you once you arrive and will be able to answer any questions or concerns you have with the procedure.

FREQUENTLY ASKED QUESTIONS

What is a sleep study?

A sleep study contains 16 or more different measurements used for monitoring your sleep patterns. These measurements are primarily EEG (brain wave activity) and respiratory (breathing). The study will record for 6 or more hours while you sleep. Your sleep technician will greet you when you arrive and will explain the procedure as he/she is applying the necessary measurement sensors. The procedure for applying the sensors will usually take between 30 minutes to 50 minutes.

What is MSLT study?

The MSLT is a full-day test that consists of five scheduled naps separated by two-hour breaks. During each nap trial, you will lie quietly in bed and try to go to sleep. Once the lights go off, the test will measure how long it takes for you to fall asleep. You will be awakened after sleeping 15 minutes. If you do not fall asleep within 20 minutes, the nap trial will end. Please bring light breakfast and snacks for daytime study.

The MSLT will last most of the day. Usually the MSLT sleep study will end around 2 PM. The night before your MSLT you will have an overnight sleep study. For the MSLT to be accurate, you will need to sleep at least six hours during the overnight sleep study.

What are the sensors used for the sleep study?

The measurements are:

- EEGs - 6 sensors placed in your scalp area held in place with a water-soluble paste or adhesive. Your hair is not cut or shaved and the leads are painlessly placed and removed in the morning. These sensors are the main sensors used in determining if you are asleep or awake. If asleep, there are 4 different stages of sleep that are registered and recorded on the computer.
- Eye movements - 2 sensors, one near each eye but not touching your eyes in any way. Each sensor is applied with an adhesive. Eye movements are also used in determining the different stages of sleep.
- Muscle activity - 2 or 3 sensors applied on your chin or jaw line. These sensors are also applied with an adhesive and are used in determining the different stages of sleep.
- ECG - 2 sensors placed near the left and right shoulder/chest area. These sensors are applied with adhesives and measure your heart's activity during the study.
- Leg movements - 4 sensors, two sensors each placed on the left and right leg around your calf/shin area applied with adhesives. These sensors measure leg movement activity during your sleep.
- Breathing - 2 sensors placed under the nose and above your upper lip used to determine your breathing patterns during the study. One sensor is a soft plastic wire sensor w/ prongs just under each nostril and over your mouth. This sensor acts as a thermometer recording air you breathe in (cold air) and air you breathe out (warm air) and is recorded as a waveform.
- Oximeter - a sensor placed on your finger used to record the oxygen level in your blood. This sensor is placed with adhesive and a low illuminating red light is used to read the level of oxygen.
- Breathing effort - Two belts placed one around your chest and one around your stomach used to determine your breathing effort by stretching and contracting as you breathe in and out during your sleep study.

FREQUENTLY ASKED QUESTIONS (con'd)

Will you give me any medication to help me sleep?

No. This might change your sleep patterns and prevent us from identifying the source of your sleep problem. However, you may take whatever medication you usually take before bedtime. Be sure to inform the technician running your sleep study of what medications you are taking.

What happens if I need to go to the bathroom in the middle of the night?

All sensors are attached to a central box which you will be able to carry with you once detached from the main computer cable. This is a very simple process and can be done in a few seconds to allow you mobility to use the restroom whenever needed.

Will anyone else be in the sleep laboratory while I am there?

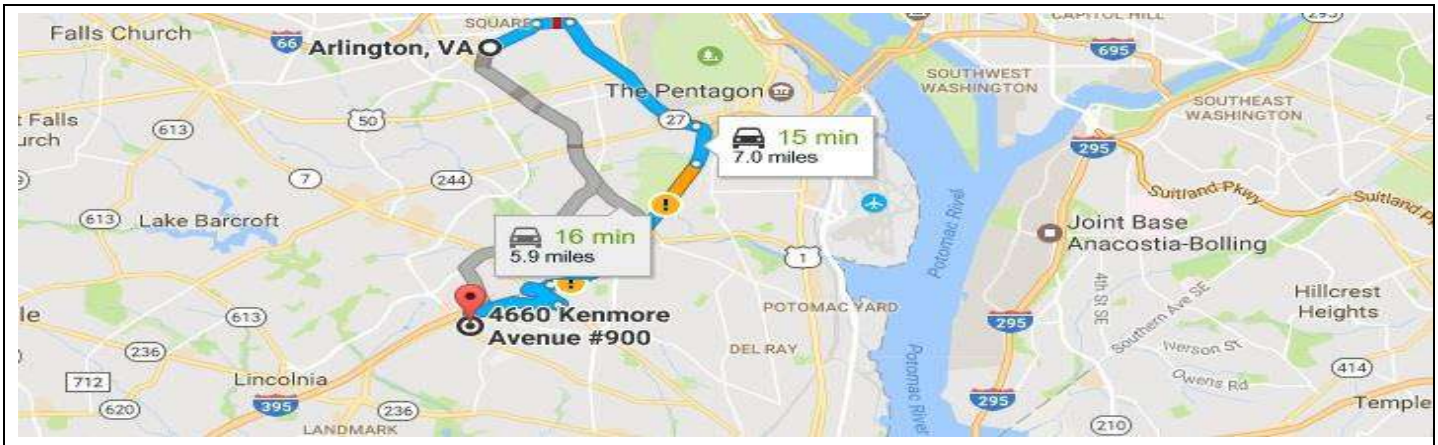
A technician will greet you once you arrive at the sleep lab and show you to your room. A member of our technical staff will be present and available to you during your entire night at the sleep lab as well as possibly other patients who will also be at the lab for sleep testing purposes.

When can I leave?

Usually the sleep study will end between 05:00 AM and 07:00 AM. Removal of the sensors usually takes just a few minutes and once done, you may leave at any time thereafter. There will also be a short morning questionnaire. If you need to be up earlier, please notify the technician.

Google Maps & Directions for CSC, Alexandria Medical Center

4660 Kenmore Ave, Suite 900, Alexandria, VA 22302



FROM ARLINGTON, VEINNA or FAIRFAX	FROM Interstate 495
Go to Leesburg Pike/VA-7 E. Continue to follow VA-7 E. towards Old Town Alexandria 1.Turn slight right onto N Beauregard St. left Seminary Rd 0.5 mi Turn left onto Library Ln 164 ft Turn left Destination will be on the left o	Go onto I-395 S Take exit 57B for Interstate 395 N toward Washington 0.9 mi Merge onto I-395 N 3.6 mi 16. Take exit 4 for Seminary Rd 164 ft Turn left Destination will be on the left

If you have any questions please call at phone # 571-261-9877 or fax at 571-248-0583 or click here to email us