Thank you for choosing Atlantic General Hospital for your sleep testing procedure! Your physician has ordered you to have a home sleep test (HST), to determine if you may have sleep apnea. Sleep apnea is a night time disorder characterized by either brief pauses in your breathing, or periods of very shallow breathing during the night. This study is designed to be performed in the comfort of your own home. You will make an appointment with the sleep lab to pick up your home sleep testing equipment. During this appointment you will become familiar with the device. You will be given detailed instructions on how to hook up the home sleep equipment for use overnight, as well as the opportunity to demonstrate how to set up and operate the home sleep equipment, to ensure that you are comfortable with this testing once you get home. Please be sure to address any questions and/or concerns that you may have about testing at this appointment. Our goal is for you to have a comfortable and successful testing experience.

You will also be given a return appointment at which time you will bring your home sleep testing device back to the sleep lab. At this point the technologist can verify that all necessary information was collected and that the test is valid. You can address any additional questions or concerns at this time as well. You will then be instructed to make a follow up appointment with your referring provider (if you have not already done so), so that he or she can go over the results with you. We look forward to working with you!

Sleep History:
Please circle all that apply:

Daytime Sleepiness	Trouble Concentrating	Doze while driving	Memory Loss
Snoring	Gasping	Choking	Restless Sleep
Shortness of Breath	Difficulty getting to sleep	Teeth Grinding	Insomnia
Irritable	Anxiety	Pain	Restless legs
Vivid dreams	Depressed	Mood Swings	Sweating
Nightmares	Sleep Talking	Sleep Walking	Yelling Out
Morning confusion	Difficulty staying awake	Feel tired/exhausted	Morning headaches
Morning sore throat/dry mouth	Morning feeling of paralysis of arms/legs	Family history of sleep apnea	
Frequent urination at night? (how often? ___)	Periods of waking up (how many? _____)	Nap during day How long? _____	

Normal sleep position? Side Back Stomach

Height: _____ Weight: _____

Shift Work: YES NO If YES what are your hours? _____

Have you been diagnosed with sleep apnea before? _____

If yes: When? _____ Where? _____

Do you use CPAP therapy at home? _____

What pressure is your CPAP machine set on? _____

If you do not wear your CPAP at night please state why:
_____

Please list all medications with dose, how often, reason:
_____
_____
_____

How likely are you to doze off or fall asleep in the following situations?

Use the following scale to choose the most appropriate number for each situation. Circle the appropriate answer:

	Never	Slight Chance	Moderate Chance	High Chance
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place	0	1	2	3
Car passenger for one hour, no break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch, no alcohol	0	1	2	3
Driver stopped in traffic for a few minutes	0	1	2	3

A score of 10 or higher indicates a possible sleeping disorder. If your score was 10 or higher, please see your physician about scheduling a sleep study for further evaluation.

***Name:*_____*Score:*_____**

ATLANTIC GENERAL HOSPITAL care.givers	DIAGNOSTIC SLEEP DISORDERS CENTER Epworth Sleepiness Scale	

Your home sleep testing package should come with the following equipment:

__ 1 NOX – T3 device

__ 1 nasal cannula

__ 2 RIP belts (1 chest and 1 abdomen)

__ 1 Bluetooth oximeter

The device is designed to be worn over your night clothes. Follow these steps to set your equipment up.

- Use the clips to attach the device to your shirt or pajama top at armpit height in the center of your chest. A shorter wire should hang down from the device.
- Upper and lower belts will already be attached to one side of the monitor
- Wrap top belt around the back and bring to the front of your chest securing it to the other side of the device
- Wrap lower belt around the back and bring to the front of the abdomen securing it to the lower attachments
- Remove Long lasso shaped tubing (cannula) making sure prongs are curved down and towards the back of your throat
- Place one prong in each nostril and tubing over and around each ear. Slide fastener underneath your chin to make the cannula tight enough to stay on, but not so tight that it is uncomfortable.
- Insert other end of cannula into top hole nox T3 device should be able to wiggle it and not detach
- Place watch like mechanism on the wrist of your non-dominant hand and secure it in place using Velcro strap, again tight enough to stabilize it but not so tight that it is uncomfortable.
- Place probe over index finger of the same hand making sure that you finger is inside the probe and that the tip of your finger is not sticking out the top. Make sure one of the squares on the probe is directly above your finger nail by pressing down on the square.

Your unit will automatically start at _____.

Once the recording has started you will see the green light to verify that the unit is on. Please state your name, date of birth and today's date for validity.

Relax and enjoy your night. Please feel free to sleep in any position and move normally throughout the night. The goal of this study is to get a snapshot that is as close to your normal night sleep as possible.

Your unit is set to automatically cease recording at _____. If you sleep longer than that it is okay. Once you wake up in the morning, you may disconnect the equipment and put it back in the carrying case.

Your return appointment is scheduled for _____. Please remember to bring the device back with you. This is not an appointment for results. You will need to make an appointment with your referring physician _____ in approximately 2 weeks for them to go over the results with you. We look forward to seeing you!

Your signature below verifies that you have been made aware that the HST equipment must be returned to the AGH sleep lab no later than _____. Failure to do so may result in you being held financially responsible for any and all costs associated with replacing equipment.

X_____ (Patient or Patient representative)

X_____ (AGH Technologist – witness)

Patient Name: _____

Account # _____

D.O.B: _____

Date: _____

Tech:_____

Referring Dr: _____

Insurance: _____

Height: _____

Weight:_____

BMI _____

Neck _____

ESS_____

Date and time of equipment pick up _____

Date and time of equipment return _____

Pt was given hook up instructions verbally and in writing _____

Additional information_____
_____
_____
_____
_____
_____

ATLANTIC GENERAL HOSPITAL care.givers	DIAGNOSTIC SLEEP DISORDERS CENTER TECHNICAL SUMMARY HOME SLEEP TESTING	

HOME SLEEP TEST SATISFACTION SURVEY

Name: _____ Date: _____

1. Were you scheduled in a timely manner? _____
2. Did the scheduler address any questions or concerns you had prior to your appointment?

   _____
3. Did the sleep technologist introduce themselves? _____
4. Do you feel that you received enough information about the use of your home sleep testing device prior to taking it home?

   _____
5. Did you have any problems with the home sleep testing device? _____
6. Did you find the home sleep testing device easy to use? _____
7. Were you given post-test instructions on receiving your results? _____
8. Were all of your post-test questions answered by the technologist at your return appointment?

   _____
9. Additional questions or comments

   _____
   _____
   _____
   _____