Please arrive no more than 15 minutes prior to your appointment. The hook up will take approximately one hour and your study will begin shortly afterwards. Your sleep study will end between 5:00 and 5:30 am. If you need to arrive earlier or be awakened before 5:00 a.m., let us know in advance so we can adjust the schedule.

Our Sleep Center staff will make your stay with us as pleasant as possible. If you have any questions or concerns, feel free to contact us between 9am to 5pm Monday - Friday at 512-452-0004 (option 2). Thank you for choosing REM Sleep Center. We look forward to helping you soon!

**About your sleep study**

A sleep study is a diagnostic procedure which measures physiological parameters during sleep. This is a noninvasive procedure meaning that no needles will be involved and the procedure is painless. A sample of your sleep patterns is needed to help diagnose any sleep disorders. Body sensors are used to allow us to monitor and record the quality of your sleep. They are applied so that you may turn and move in your sleep as you normally would. Surprisingly, most people will sleep the way they usually do at home. A technician will be available for assistance all night and bathroom visits are easily accommodated. Our staff will try to make your sleeping environment as comfortable as possible. Please remember, this is not a performance test, only a sample of how you sleep.

The following parameters will be monitored during your study:
- EEG/Brain Waves (Electrodes placed on the scalp)
- EKG/Heart Rate (Electrodes placed on the chest)
- EOG/Eye Movements (Electrodes placed above and below eyes)
- EMG/Muscle Tension (Electrodes placed on the chin)
- EMG/Muscle Tension (Electrodes placed on both legs)
- Airflow/Breathing (Sensors attached near nose and mouth)
- Respiratory Effort (Elastic belts placed around chest and stomach)
- Oximetry/Blood Oxygen Levels (Small sensor attached to finger)

***Please review the following page to ensure you are properly prepared***
If you did not do so at scheduling, please let us know prior to your sleep study if you:

- Currently use CPAP/BiPAP and/or supplemental oxygen at home
- Need assistance getting in and out of bed
- Cannot walk up and down stairs on your own
- Have hair extensions and/or weaves. These can obstruct access to your scalp
- Have any neurological deficits.
- Have any sensitivities to adhesives such as tape.

What we need from you is the following:

- Complete and sign the enclosed paperwork prior to your arrival.
- Please bring a list of any medications you currently use.
- Please bring all insurance cards and a photo ID.
- Bathe and make sure that your hair is clean and free from all oils, gels or sprays and make-up. It is important that the technologist have access to your scalp.
- Bring something comfortable to sleep in (pajamas, tee-shirt and shorts along with a robe for comfort.)
- DO NOT wear silk, satin, or nylon – they can cause static and may interfere with the study.
- If you use CPAP/BiPAP at home, please bring your mask and headgear.

Helpful hints for the day of the study:

- Make sure to bring any medications you will need for the night. If you have difficulty initiating and/or maintaining sleep, you may want to discuss this with your referring physician to ask about a sleep aid. Do not take any sleep aids prior to arrival for your study and let your technologist know when and what you are taking.
- Avoid caffeine and alcohol after 4pm.
- Please be clean shaven unless you normally wear a beard.
- If you have something from home that would make your stay more comfortable (such as a favorite pillow) please feel free to bring it with you.
- If you have a cold or feel ill, please contact the lab immediately as we may need to reschedule.
Directions to REM Sleep Center – Round Rock: On I-35 take the exit for RM-1431/Cedar Park and University Blvd., go East on University Blvd., which is just North of the IKEA. In about 0.5mi take a right on Cypress Blvd. and travel another 0.5mi and the destination will be on your right in an office park. The Sleep Lab is located in the same offices as ProvidaCare towards the North end of the building.
WHAT IS A POLYSOMNOGRAM?

A Polysomnogram is a diagnostic procedure which measures physiological parameters during sleep.

The following parameters will be monitored during your study.

- EEG/Brain Waves (Electrodes placed on the scalp)
- EKG/Heart Rate (Electrodes placed on the chest)
- EOG/Eye Movements (Electrodes placed above and below eyes)
- EMG/Muscle Tension (Electrodes placed on the chin)
- EMG/Muscle Tension (Electrodes placed on both legs)
- Airflow/Breathing (Sensors attached near nose and mouth)
- Respiratory Effort (Elastic belts placed around chest and stomach)
- Oximetry/Blood Oxygen Levels (Small sensor attached to finger)

1. WHY RECORD ALL THESE THINGS?

During sleep, the body functions differently than while awake. Disrupted sleep can disturb daytime activities and sometimes-medical problems during sleep involve a risk to your basic health.

2. HOW CAN I SLEEP WITH ALL THESE THINGS ON ME?

We hear this all the time, Surprisingly; most people will sleep the way they usually do at home. A sample of your sleep patterns is needed to help diagnose any sleep disorders. The body sensors are applied so that you may turn and move in your sleep as you normally would. This is a noninvasive procedure meaning that no needles will be involved and the procedure is painless. Our staff will try to make your sleeping environment as comfortable as possible. Remember, this is not a performance test, only a sample of how you sleep.

3. WILL THE ELECTRODES/SENSORS HURT?

No! Occasionally, in rubbing the skin while attaching the electrodes, there may be a mild and temporary skin irritation. Generally, this does not cause any significant discomfort.

4. WILL I BE GIVEN A DRUG TO HELP ME SLEEP?

REM Sleep Center will not “automatically” give you a medication for sleep. However, if your physician has prescribed sleeping medication for you, you should continue taking this and all other medications as ordered by your doctor.
CUSTOMER ACCOUNT AGREEMENT

***Please take the time to carefully read before signing***

1) Unless prior arrangements have been made with the Bookkeeping Dept., full payment of the bill is due at time of service.

2) Unless prior arrangements have been made with the Bookkeeping Dept., the patient is responsible for any and all portions of the bill not paid by insurance.

3) If you believe there is an error in your bill you will contact the Bookkeeping Dept., within 10 days of receipt of your statement.

X

Patient/Caregiver   Date    Technician’s Initials

INFORMED CONSENT TO PHOTOGRAPH AND/OR VIDEO TAPE

***Please take the time to carefully read before signing***

Photographs may be taken for documentation of any facial, nasal, jaw or neck abnormalities. Videotaping or obtaining digital video and audio is done in all Sleep Testing to document cases of unusual behavior or breathing patterns connected with sleep disorders. I understand that these photographs and/or videotapes will be a part of my medical record and are not for publication. I hereby grant permission REM Sleep Center to take photographs and/or use digital video and audio recording.

X

Patient/Caregiver   Date    Technician’s Initials

INFORMED CONSENT FOR CPAP/BIPAP TITRATION

***Please take the time to carefully read before signing***

I hereby acknowledge that I have been informed of and understand the purpose of the treatment of Continuous or BiLevel Positive Airway Pressure (CPAP/BiPAP) and the associated risks (listed below) and alternatives, and that I have had the opportunity to have my questions concerning treatment answered by a qualified technician.

Risk Factors Associated with PAP Therapy:
Aspiration, Nasal Congestion, Minor Eye Irritation, Shortness of Breath, and Skin Irritation

X

Patient/Caregiver   Date    Technician’s Initials
**MEDICAL HISTORY QUESTIONNAIRE**

Referring doctor (MD, DO, DDS, Etc.): ________________________________

Date of Birth: _____________________ Age: _____________ Height: ______________Weight: _______________

Address: ______________________________________  Home Phone: ____________________________________

______________________________________  Email Address: ___________________________________

**SYMPTOMS CHECKLIST**

1. Do you snore? Yes ___No ___ Sometimes____
2. Do you stop breathing in your sleep? Yes ___No ___ Sometimes____
3. Do you awaken suddenly with a choking sensation? Yes ___No ___ Sometimes____
4. Do you awaken with headaches in the morning? Yes ___No ___ Sometimes____
5. Do you have trouble breathing through your nose? Yes ___No ___ Sometimes____
6. Do you awaken with a dry mouth? Yes ___No ___ Sometimes____
7. Do you awaken at night to urinate? Yes ___No ___ Sometimes____
8. Do you have restless legs? Yes ___No ___ Sometimes____
9. Do you feel sleepy during the day? Yes ___No ___ Sometimes____
10. Do you feel fatigued during the day? Yes ___No ___ Sometimes____
11. Do you have problems with memory or concentration? Yes ___No ___ Sometimes____

List all prescription and other medications: [PLEASE PRINT VERY CLEARLY] - use back if necessary

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Reason for Medication</th>
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</table>
MEDICAL HISTORY (Check all that apply)

<table>
<thead>
<tr>
<th>Do you now have or ever had:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure (HTN)</td>
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<td></td>
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<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td></td>
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<tr>
<td>Nocturnal Esophageal Reflux (GERD)</td>
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<td></td>
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<tr>
<td>Mood Disorders</td>
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<td>Heart Problems</td>
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<tr>
<td>Ischemic Heart Disease</td>
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<tr>
<td>History of Stroke</td>
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<tr>
<td>Diabetes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you now have or ever had:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal Fracture</td>
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<td></td>
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<tr>
<td>Nasal Surgery</td>
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<tr>
<td>Sinus Problems</td>
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<td>Allergies</td>
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<td>Asthma</td>
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<td>Insomnia</td>
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<td>Tonsillectomy</td>
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<tr>
<td>Swelling of Hands or Feet</td>
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</table>

SLEEP RELATED HEALTH-CARE:

1. Have you ever had a sleep study?
   a. If so, when was it done?
   b. Who ordered it?
   c. Where was it done?

2. Are you on CPAP/BiPAP therapy?
   a. If so, when did you start?
   b. What is your pressure setting?
   c. Who supplied your machine?

3. Are you on home oxygen?
   a. If so, when did you start?
   b. What company supplies your oxygen?

List all major surgeries: [PLEASE PRINT VERY CLEARLY] – use back if necessary

Please describe the sleep-related issue that brings you to the sleep center:
EPWORTH SLEEPINESS SCALE

Please rate the chance of you dozing in the following situations:

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3= high chance of dozing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
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<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g. theater or <strong>meeting</strong>)</td>
<td></td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td></td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td></td>
</tr>
</tbody>
</table>

Add the numbers for a total: __________________________________

SOCIAL HISTORY

Have you ever smoked?  Yes ______ No ______
If yes, for how many years? _______________________
Average number of packs per day? _______________________
Have you quit smoking?  Yes ______ No ______
How long ago? _______________________

Do you drink caffeinated beverages?  Yes ______ No ______
If yes, how much per day? _______________________
Do you drink alcoholic beverages?  Yes ______ No ______
If yes, how many drinks/wk? _______________________
Do you get regular exercise?  Yes ______ No ______
If yes, how often? _______________________

SLEEP HABITS

Normal Bedtime: Weeknights: _________ Weekends_________
Normal Wake up time: Weekdays:_________ Weekends_________

What position do you prefer to sleep in?  ___ Back ___ Stomach ___ Side

In a typical night, how many times do you wake to use the restroom? __________

Do you sleep with a fan or noise-maker? ___ Yes ___ No

Additional Notes:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________