



## Mercy Sleep Center

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## Mercy Sleep Center - Logan

200 S Academy Rd.  
Guthrie, OK 73044  
405.936.5208  
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### How to prepare for your overnight sleep study

1. **We have scheduled a Registered Sleep Technologist to work the night of your study specifically for you. If you are unable to make your appointment for any reason, we ask that you call us so that we may notify the Sleep Technologist that they do not need to come to the Sleep Lab. 405.936.5208 Thank you, We appreciate your consideration.**
2. **Do not** drink anything with caffeine in it after 2 p.m. on the day of your study (this includes coffee, tea, soft drinks, ETC.)
3. **Do not** drink any alcohol on the day of your sleep study.
4. **Do** wash and dry your hair without gels or hairspray.
5. **Do** take your medications as prescribed by your doctor, unless otherwise directed by your doctor, **if you take any medications that may make you sleepy please do not take until you arrive at the sleep center.** The Sleep Center doesn't have the ability to dispense any medication, including any over-the-counter medications such as aspirin.
6. **Do** bring insurance card and picture ID.
7. **Do** bring co-pay or estimated amount due.
8. **Do** wash your face to remove any oils and makeup before arrival.
9. **Do** shave facial stubble (Men). Full beards should be clean.
10. **Do** bring your own pillow if you feel it will help you sleep.
11. **Do** bring comfortable pajamas or loose fitting clothing to sleep in (If you have no sleepwear, you will be provided a hospital gown).
12. **Do** bring something to do if you are scheduled for testing the following day.
13. **Do** make overnight arrangements for those traveling with you. We have no facility at the hospital. Please call the sleep center for the hotel information
14. **Do** plan to be awakened early (6 a.m.). You will be ready to depart by 7 a.m.
15. **Do** call Mercy Sleep Lab if you have any questions at 405.936.5208 after 8 p.m.
16. Due to our electrodes, All hair pieces and/or weaves must be removed prior to your scheduled appointment.
17. If the patient is a minor, a parent or legal guardian must also plan to spend the evening.
16. **Please notify us of any cancellations within 48 hours of your scheduled appointment.**

**\*Please note: The Sleep Technicians arrive nightly at 8 p.m.**

# Understanding your health just got easier



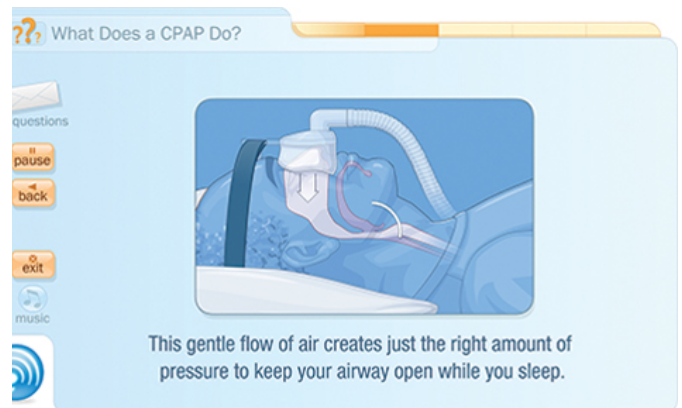
Ask Your Doctor About Emmi

## What is Emmi?

Emmi® is a series of free, animated online programs that walk you through important information about what you need to know before your sleep study. You can watch Emmi programs as many times as you like and you can share them with your family and friends.

## Learn More About Your Health

Doctors try to explain everything about your health but sometimes it gets confusing. Emmi programs help to answer your questions and make you feel more at ease about your experience in the sleep lab. You are the most important member of your health care team, so you should have all the information you need.



© 2014 Emmi Solutions, LLC. CPAP (Continuous Positive Airway Pressure) for Sleep Apnea program



© 2014 Emmi Solutions, LLC. Sleep Study program

Ready to learn more?

**Look out for your Emmi instructions via MyMercy, your email and/or a phone call from us!**

Need Help?

**Email:** [support@emmisolutions.com](mailto:support@emmisolutions.com) **Phone:** 866.294.3664

## Introduction to Obstructive Sleep Apnea and Nasal CPAP Therapy

This information is presented to help you better understand your sleep disorder and the treatment. We will answer some of the more common questions about sleep apnea and Nasal CPAP.

### What is Sleep Apnea?

Sleep apnea refers to a condition that occurs while you are sleeping when no air is able to get into your lungs.

### What happens to a person who has sleep apnea?

When movement of air in and out of your lungs is disturbed, less oxygen is delivered to the blood. This causes you to wake up many times during the night. As a result, you don't get enough of the right kind of sleep.

### How do you know you have this?

Your doctor will order (or had ordered) a test that evaluates your sleep patterns. Small painless electrodes are applied to monitor brainwave activity (to help determine sleep stages), EKG (heart rate), EMG (muscle activity), and EOG (eye movements). A thermocouple placed under your nose is used to monitor airflow, electrode belts are used to monitor respiratory chest effort and abdominal effort, and a flexible probe is placed on your finger to monitor your blood oxygen saturation. In addition, a snore microphone is used to determine the amount of the night you spend snoring. The technician will monitor these channels of information on a computerized polysomnographic machine.

### How will Nasal CPAP Help?

The nasal CPAP system works to prevent the structures in the throat from blocking air movement in and out of your lungs. To do this a small amount of pressure is applied through your nose. The pressure works to keep the airway open, which allows air to move from your nose to the top of your windpipe. It splints the airway open with air.

**As long as you are able to move air in and out of your lungs, you will have enough oxygen. Your sleep will no longer be disturbed by too little oxygen. Thousands of people worldwide are already using this system.**

### How do you use Nasal CPAP treatment?

You will need to use Nasal CPAP only during the time you normally sleep. You will receive thorough instructions at the Sleep Diagnostic Laboratory and from your home care dealer before using it at home.

You and your family will learn how to connect tubing and valves and how to operate the blower unit. With the proper training, the equipment is easy to use.

### Is this therapy dangerous?

The sleep study allows your doctor to know how much pressure you will need to be sure you get just enough to treat apnea. The equipment you are using at home can't be accidentally adjusted to levels other than what your doctor ordered. Pressure levels prescribed are very low. In fact, you build up more pressure in your lungs when you cough or sneeze.

If you lose your electrical power or should you displace the mask during sleep, you will continue to breathe through your mouth as you usually do.

**How long will I need Nasal CPAP?**

This will depend upon a number of factors. To be most effective, you must follow the treatment plan worked out for you by your doctor and consult your doctor if you have any questions or problems.

If you have Obstructive Sleep Apnea Syndrome, your doctor may prescribe weight loss as well as Nasal CPAP therapy.

**What will Nasal CPAP do for me?**

Nasal CPAP will help you breath better during your sleep. This means you won't interrupt your sleep during the night and you will be able to get enough of the right kind of sleep. You should notice some of the following effects:

1. Less daytime sleepiness.
2. Feeling more alert.
3. Improved memory.
4. More motivation.
5. Better work performance.
6. An overall improved outlook on life.

We are happy to have the opportunity to help you. If you have any questions before or after the sleep study, please call us and leave a message at the phone number below. One of the technicians will call you back as soon as possible.

## Epworth Sleepiness Scale

Name: \_\_\_\_\_ Date: \_\_\_\_\_

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations. This refers to your usual life in recent times, even if you have not done some of these 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

- |  |       |
|--|-------|
| 1. Sitting and reading   | _____ |
| 2. Watching Television   | _____ |
| 3. Sitting inactive in a public place (i.e. theater or meeting)  | _____ |
| 4. As a Passenger in a car for 1 hour without a break.           | _____ |
| 5. Lying down to rest in the afternoon when circumstances permit | _____ |
| 6. Sitting and talking to someone                                | _____ |
| 7. Sitting quietly after lunch without alcohol                   | _____ |
| 8. In a car, while stopped for a few minutes                     | _____ |
| <b>Total</b>   | _____ |

### Sleep Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

Please give the completed questionnaire to the technician at the time of your sleep study.

My primary sleep complaint is: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Have you ever seen a physician for this problem? \_\_\_\_\_

Have you ever had a sleep study? \_\_\_\_\_

(If yes, when and where) \_\_\_\_\_

Do you use CPAP at Home? What Pressure? \_\_\_\_\_

If currently using CPAP what is the need for this study? \_\_\_\_\_

Do you use Oxygen at Home?  No  Yes  24HR/DAY  Night Only

Medication	Dosage	Reason for taking

**Pertinent Medical History** *(check those that apply)*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Memory Loss                             | <input type="checkbox"/> Nighttime Heartburn  |
| <input type="checkbox"/> Kidney Failure         | <input type="checkbox"/> Seizures                                | <input type="checkbox"/> Allergies  |
| <input type="checkbox"/> Cerebral Palsy         | <input type="checkbox"/> Parkinson’s Disease                     | <input type="checkbox"/> CHF (Congestive Heart Failure)                             |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Mood Disorder                           | <input type="checkbox"/> Smoker: Cigarettes, Vape, Cigars<br><i>(Please Circle)</i> |
| <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Fibromyalgia                            | <input type="checkbox"/> History of Motor<br>Vehicle Accident                       |
| <input type="checkbox"/> Premature Birth        | <input type="checkbox"/> History of Sports<br>Related Concussion |   |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Head Injury                             |   |
| <input type="checkbox"/> Thyroid Disease        | <input type="checkbox"/> Neuromuscular Disease                   |   |
| <input type="checkbox"/> Heart Attack           |  |   |

**Chronic Lung Conditions** *(Please Check Only Those That Have Been Diagnosed By Your Physician)*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Occupational Lung Disease |
| <input type="checkbox"/> Lung Cancer            | <input type="checkbox"/> ALS                | <input type="checkbox"/> Bronchiectasis            |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Myasthenia Gravis         |
| <input type="checkbox"/> Cystic Fibrosis        | <input type="checkbox"/> COPD               |  |

**Surgeries** *(check those that apply)*

- |                                   |  |   |
|-----------------------------------|--|---|
| <input type="checkbox"/> Tonsils  | <input type="checkbox"/> Deviated Septum | <input type="checkbox"/> Tracheotomy        |
| <input type="checkbox"/> Adenoids | <input type="checkbox"/> Uvula Removal   | <input type="checkbox"/> Jaw Reconstruction |
| <input type="checkbox"/> UPPP     | <input type="checkbox"/> Nasal Polyp     | <input type="checkbox"/> Nasal Surgery      |

**Sleep Pattern**

What is your normal bedtime? \_\_\_\_\_

What time do you normally awaken? \_\_\_\_\_

How long does it usually take you to fall asleep? \_\_\_\_\_

Do you awaken often during the night? \_\_\_\_\_

(If yes, Why?) \_\_\_\_\_

Do you nap during the day? \_\_\_\_\_

(If yes, do you feel refreshed upon awakening?) \_\_\_\_\_

Do you work different shifts? \_\_\_\_\_

(If yes, what shift(s) do you work?) \_\_\_\_\_

**Place a check mark in front of any statement that applies to your sleep patterns, If the statement does not apply leave it blank.**

**Excessive Daytime Sleepiness**

- I fall asleep at work.
- I get sleepy while driving.
- I have fallen asleep while driving.
- I fall asleep at meetings.
- I don't feel refreshed when I awaken.

**Restless Leg Syndrome or Nocturnal Myoclonus**

These questions help to determine if you have Restless Leg Syndrome. *(Please check the appropriate answer.)*

1. Do you have the urge to move legs while awake, usually accompanied by an uncomfortable feeling in the legs.  
 Yes  No
2. Does rest or inactivity worsen the symptoms?  
 Yes  No
3. Do your symptoms get better with activity?  
 Yes  No
4. Do your symptoms get worse in the evening or night?  
 Yes  No
5. How often do you experience the symptoms above?  
 Rarely  
 A few times a month  
 More than 2 times a week  
 Almost Everyday

**Insomnia**

- I have trouble getting to sleep at night.
- I have trouble staying asleep at night.
- I awaken in the morning long before I want to.
- I worry I will be unable to sleep.
- I awaken with feelings of anxiety or fear.

**Sleep Behavior**

- I have been told I walk in my sleep.
- I have been told I talk in my sleep.
- As an adult, I have wet the bed.
- When I laugh or get angry, I feel like I'm going limp.
- I have fallen asleep while laughing or crying.
- I have vivid dream-like scenes upon falling asleep.
- I feel like I walk around in a daze.
- Sometimes I can't tell dreams from reality.

**Sleep Apnea**

- I have been told that I snore
- Others can't sleep in the same room because I snore.
- I have been told I stop breathing while asleep.
- I awaken with headaches.
- I'm overweight or am gaining weight.
- I perspire at night.
- I have been told I'm a restless sleeper.
- I have awakened during the night choking.