10 Page Drive • Post Office Box 1749
Pinehurst, North Carolina 28370
Phone: 910-295-6868 Fax: 910-295-1514

Dear Patient:

We ask that you review and complete this information packet prior to your scheduled study and **bring the completed packet with you at the time of your study.**

Because the test requires that your breathing patterns be observed at night, you will be spending the entire night at the Sleep Center. YOU WILL BE ABLE TO DRIVE YOURSELF HOME. In the event you need to arrange transportation with someone else, you should ask them to drop you off at your scheduled appointment time and ask them to pick up at 6:30am the next morning.

When you arrive at our office on the evening of your study, please ring the doorbell located on the brick wall to the left of the front door and the technologist will greet you, as the door will be locked.

In case you run into a last minute delay in arriving at the office on the evening of your study, please contact the technologist directly by calling the office after 8:00 pm. Please call 910-295-6868 extension 7995. Please leave a message if the technologist doesn't answer, as they may be assisting another patient.

A sleep technologist has been scheduled for the sole purpose of conducting your test. **If you are unable to keep your appointment, please be courteous and cancel or reschedule at least 24 hours in advance.** We reserve the right to charge a $100 fee for missed appointments.

We appreciate your confidence in using our facility. If you have any further questions or concerns about your appointment, please feel free to call us. You may call our office Monday – Friday 8:00am – 430pm at 910-295-6868. We look forward to serving your medical needs.

Sincerely,

The Physicians and Staff of Pinehurst Neurology, P.A.

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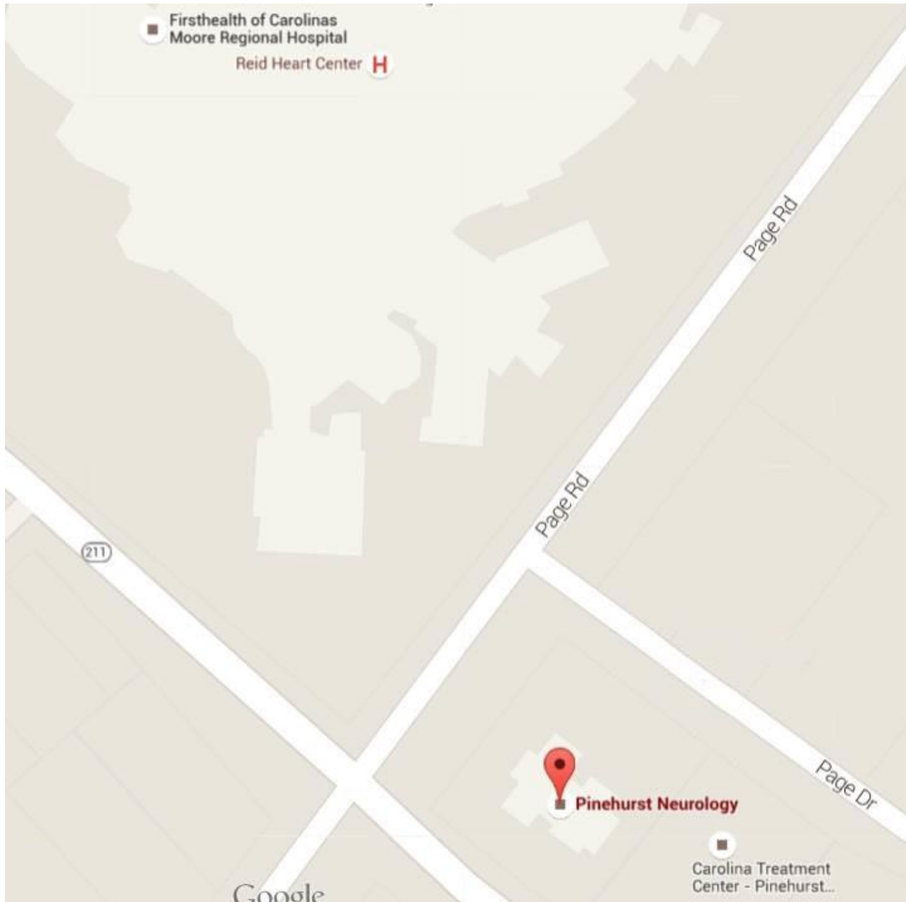
Directions

From the Rockingham Area: Take US 1 North to Aberdeen. At Aberdeen, turn left onto Hwy 15-501 North at stop light. (You will see a green Hwy sign above light for 15-501.) Continue until you reach the traffic circle. (Approximately four miles.) Take the Hwy 211/Candor fork. At the first light you come to, make a right (Page Road). Make your next right onto Page Drive and we are first parking lot on the right.



From the Laurinburg Area: Take15-501 North to Aberdeen. At. Aberdeen, turn left onto Hwy 15-501 North at stop light. (You will see a green Hwy sign above light for 15-501.) Continue until you reach the traffic circle. (Approximately four miles.) Take the Hwy 211/Candor fork. At the first light you come to, make a right (Page Road). Make your next right onto Page Drive and we are first parking lot on the right.

From Fayetteville Area: Begin on Route 401 and continue 23 miles toward Raeford. Turn off onto Hwy 211-West towards Aberdeen. At intersection of 211 and US 1, turn right onto US 1 and go approximately 4 miles. . At. Aberdeen, turn left onto Hwy 15-501 North at stop light. (You will see a green Hwy sign above light for 15-501.) Continue until you reach the traffic circle. (Approximately four miles.) Take the Hwy 211/Candor fork. At the first light you come to, make a right (Page Road). Make your next right onto Page Drive and we are first parking lot on the right.

From Sanford Area: Take US 1 South towards Southern Pines. Bear right onto 15-501. Continue until you reach the traffic circle in Pinehurst. Take the Hwy 211/Candor fork. At the first light you come to, make a right (Page Road). Make your next right onto Page Drive and we are first parking lot on the right.

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Patient Checklist & Instructions – Sleep Study

You have been referred to Pinehurst Neurology, PA Sleep Center for testing. In order to make your stay in the laboratory more comfortable we ask you to bring the following items the night of your sleep study:

Listed are special instructions for the test:

- Take all your daily medications. (no medications will be given by Sleep Center staff)
- Leave one finger with no polish or no fake nails. This is needed for the Pulse Oximetry readings.
- Avoid taking naps on the day of your test.
- Please avoid drinking caffeine and/or alcohol after 2pm the day of the study.
- Because sensitive sensors will be applied to the skin on your scalp, face, chest, and legs, it is important that you shower and your hair is clean and dry the night of the test.
- Please do not put any hair spray, hair gel, or oils in your hair.
- Please remove any weaves or extension because they prevent access to your scalp. Please do not put any lotion or oils on your skin.
- Please do not bring any valuables to the Sleep Center including jewelry, watches, purses or wallets.
- Bring any personal toiletries (toothbrush, toothpaste, etc)

**Diabetics: bring your own drinks and snacks. (Sleep lab does not provide any)

If you have any special requests or questions please direct them to the Sleep Center staff before your appointment. The office hours are 8am to 4:30pm Monday- Friday. Our office number is 910-295-6868 extension 7995.

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Name: ____ Date: ______________________

Birthdate: ____________________ Age: ________ Occupation: _________________________

Sex: ______________Height: _________ Weight: ________ Weight Last Year: __________

Referring Doctor: ______________________ Family Doctor: ___________________________

Describe your sleep problem: ____

____

What results do you expect? ____

A. SLEEP PATTERN

1. Circle the days of the week you work:
   Monday Tuesday Wednesday Thursday Friday Saturday Sunday
2. *ON WORKDAYS*
   a. What time do you go to bed:______________________
   b. What time do you get out of bed_________________
3. *ON WEEKENDS & HOLIDAYS*
   a. What time do you go to bed:______________________
   b. What time do you get out of bed:_________________
4. How long does it take for you to fall asleep?______________________
5. How many times a night do you awaken?_________________________
   a. How long do the awakenings last?______________________________
   b. List any symptoms associated with the awakenings: ______________________________

____

6. *SLEEP TIME*
   a. How many hours do you usually sleep?____________________________
   (do not include hours spent in bed awake)
   b. How many hours does it take to make you feel rested?________________________
   c. How many daytime naps do you take per week?______________________________
7. *SLEEP QUALITY*
   a. Do you feel unrefreshed and still sleepy upon awakening? **YES NO**
   b. How long does it take to fully awaken in the morning?__________________
8. In the daytime, are you chronically sleepy, fatigued or tired? **YES NO**

B. SLEEP AND BREATHING

1. Do you snore? **YES NO**
2. Is your snoring broken by hesitations, gasps and snorts? **YES NO**
3. Are the hesitations long enough to frighten your sleep partner? **YES NO**
4. Has your snoring driven your bed partner from the bedroom? **YES NO**
5. Do you awaken with a dry mouth? **YES NO**
6. Do you awaken with headaches? **YES NO**

PINEHURST NEUROLOGY
SLEEP DISORDERS LAB
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C. INSOMNIA

1. Do you have trouble falling or staying asleep? **YES NO**
2. Do you worry about being able to fall asleep on time? **YES NO**
3. Do you feel sleepy prior to getting into bed? **YES NO**
4. Does your mind race with thoughts when lying awake? **YES NO**
5. Do daytime worries keep you awake at night? **YES NO**
6. Does pain disturb your sleep? **YES NO**
7. Does heat, cold, hunger or thirst disturb your sleep? **YES NO**
8. Is your insomnia the primary reason your life is in disarray? **YES NO**
9. Do you rely on a sleeping medication? **YES NO**
10. Do you watch TV, read, or work in bed? **YES NO**
11. Do you frequently travel across 2 or more time zones? **YES NO**

D. SLEEP DISTURBANCES

1. Do you experience unpleasant leg sensations at bedtime? **YES NO**
2. Do you kick or jerk your legs and/or arms during sleep? **YES NO**
3. Do you have sweats or awaken from sleep feeling flushed? **YES NO**
4. Do you awaken with a bitter or acid taste? **YES NO**
5. Do you frequently have nightmares or vivid dreams? **YES NO**
6. Do you grind your teeth or have bitten your cheek during sleep? **YES NO**
7. Have you ever walked or talked in your sleep? **YES NO**
8. Have you ever been unable to move for a few moments after awakening? **YES NO**
9. Have you ever seen or felt things from your dreams *after* awakening? **YES NO**
10. Have you ever experienced weakness when laughing or angry? **YES NO**
11. Have you ever had unusual movements or behaviors during sleep? **YES NO**

Describe: ____

E. PERSONAL HABITS

1. Do you use tobacco now or have you in the *past*? **YES NO**
   a. If yes, how many per day and for how many years?_______ per day / ________ # of years
   b. If yes, what time of day is your last use? _______________

2. Do you drink alcohol? **YES NO**
   a. If yes, how many drinks? _______ per day / per week / per month (circle one).
   b. If yes, what time of day is your last drink? ____________

3. How many caffeinated beverages do you drink per day? __________
   a. If yes, what time of day is your last drink?_______________

F. BED PARTNER QUESTIONNAIRE

(Please have your bed partner check any and all that apply)

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□Light snoring □Sleep walking □Leg or body twitching
□Heavy snoring □Sleep talking □Leg jerking
□Pauses in breathing □Bed-wetting □Daytime sleepiness
□Snorting □Head rocking/banging □Daytime confusion
□Teeth grinding □A shaking fit □Depression/anxiety

Provide additional detail regarding any of the above. Please describe the activity, the time it occurs, and how often it occurs. ____
____

G. List any relatives who have sleep problems or snore?
________________________________ ________________________________
________________________________ ________________________________

H. List Your Medications:

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

I. Epworth Sleepiness Scale: Rate your sleepiness in the following situations:

No chance of dozing = 0 Slight chance of dozing = 1
Moderate chance of dozing = 2 High chance of dozing = 3

0	1	2	3	
				Sitting and reading
				Watching TV
				Siting inactive in a public place (theater or a 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 a lunch without alcohol
				Driving a car, while stopped for a few minutes in traffic

Add up your total. A sum of 10 or greater indicates a high likelihood of sleep disorder.

Total Score: ____________

Authorization to Discuss Medical Information

Patient Name: ________________________________ **Patient Date of Birth:** ____________

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SLEEP DISORDERS LAB
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Representative authorized to discuss/review information:
Name: ____
Address: ____
Phone: ____
Relationship to Patient: ____

Extent of Authorization (choose ONE):
A: ☐ Complete medical record including, but not limited to: appointments, medications, lab results, imaging study results, test results, plan of care. Includes records relating to: mental health, HIV/AIDS, alcohol/drug abuse).

B: ☐ Complete medical record with the exception of: mental health records, communicable disease information (HIV/AIDS), alcohol/drug abuse treatment, other: ______________________________

Effective Period:
This Authorization will remain in effect until:
A: ☐ No Expiration Date
B: ☐ Expires ________________________________ (specify expiration date or event)

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the patient.

____ Date: ______________________________
Signature of Patient or Personal Representative

____
Print or Type Name of Patient or Personal Representative

____
Description of Personal Representative's Authority (attach necessary documentation)
(PARENT/GUARDIAN, IF PATIENT IS A MINOR)