Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

SLEEP DISORDER CENTRE
Misericordia-99 Cornish Avenue
Winnipeg, MB R3C 1A2
Telephone: 204-788-8570
Fax: 204-779-8657

Your Journey Into Sleep-Level 1 Study
Sleep Disorder Centre

Please read the following important information. If after reading these instructions you have any questions, concerns or require special accommodations please contact the Sleep Disorder Centre in advance of your appointment. Cancellation or rebooking requires 48 hours notice.

FINDING THE SLEEP DISORDER CENTRE:

The Sleep Disorder Centre is located in the Misericordia Health Centre.

The Sleep Disorder Centre is not open until 8 PM. If you arrive early, please wait in the waiting area by the Information Desk at 99 Cornish Avenue until your appointment time and then proceed to the Sleep Disorder Centre lab. Please DO NOT arrive late for your appointment as we may not be able to accommodate late arrivals.

The doors at Wolseley are locked in the evening. Access to the Sleep Disorder Centre can be made in 2 ways:

1. **Misericordia-99 Cornish Avenue:**
   Enter through the Misericordia-99 Cornish Avenue entrance.
   Proceed to Elevator D. Take Elevator D to the Sleep Disorder Centre. As you exit Elevator D turn left and report to the Control Room.

2. **Parkade (located on Sherbrook Street)**
   Enter through the Parkade overpass and take Elevator B to the Main Floor. Exit Elevator B to your right and proceed to Elevator D. Take Elevator D to the Sleep Disorder Centre. As you exit Elevator D turn left and report to the Control Room.

IMPORTANT INFORMATION:

Smoking, including vaporizers, is not allowed once you have arrived to the Sleep Disorder Centre. The Sleep Disorder Centre is not responsible for the safe keeping of personal property. Only patients being studied are permitted to sleep in the testing room. Family members attending to assist patients may be accommodated in another room when pre-arranged.

If you require assistance with the following, you must arrange for a family member, Health Care Aide (HCA) or translator to assist you. Staff in the Sleep Disorder Centre are not able to assist in these areas:

- Require any assistance in taking medications.
- Require any kind of assistance in toileting, dressing, getting in and out of bed, arriving to or leaving the lab.
- Require the assistance of a translator to communicate in English.

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WHAT TO BRING/INSTRUCTIONS:

1. You **MUST** bring **2 piece, loose fitting pajamas**. A top, bottoms and underwear are **required**. **Sleeping without clothing in the Sleep Disorder Centre is NOT AN OPTION**. Nighties or once piece pajamas are not acceptable. Underwear **must** be worn.

2. Personal toiletries you may need such as toothpaste, toothbrush, sanitary garments etc. These are not available in the lab. There are no showers available.

3. Water/beverage/snacks if you will require any during the study. (Non-caffeinated)

4. Your regular medications. Please have a list of your medications.

5. If you have diabetes, we ask that you please bring your glucometer, test strips and a snack or juice as these items are NOT available in the Sleep Disorder Centre.

6. If you use oxygen you MUST bring it with you. We will supply oxygen during the test. Please ensure you have enough oxygen to travel to and from the facility, and to wait to see the physician if you have an appointment the next day.

7. If you are prescribed CPAP/BiPAP: please bring your machine, mask and headgear.

8. Partial plates, dentures, night guards or other oral appliances prescribed.

9. You may bring a book, house coat or slippers if you desire.

10. Completed copy of your Patient Sleep History Questionnaire.

The day of your test:

1. Eat a normal dinner before your study, preferably before 7 PM.

2. *No caffeine after 7 PM. No alcohol the day of testing. Refrain from napping the day of testing.*

3. ***Shower*** the day of your test, allowing time for your hair to dry.

4. Males who shave are asked to be clean shaven for their appointment. Facial stubble will interfere with our setup. Beards and moustaches are permitted.

5. Refrain from using any face or body creams, hair gels, oils, sprays, lotions, etc. as they will interfere with our equipment.

Double check that you have brought all items you will require as outlined in these instructions.

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WHAT TO EXPECT DURING YOUR APPOINTMENT:

In the Sleep Disorder Centre lab you will be greeted by a sleep tech. You will be shown to your room for testing. Your room is private. In your room there are extra pillows and blankets if you require them. Your tech will ask you to change into your **2 piece, loose fitting pajamas** and prepare for bed. Your tech will then take you to another room to be set up with the monitoring equipment. Please note other patients are present in this room.

Setup:

Several electrodes will be applied to your scalp, face, chest and legs. Note: some hair may have to be removed from the chest or legs. Hair on the head/ face is not removed.

Small areas of skin where the electrodes are to be placed will be cleaned with an alcohol pad and lightly scrubbed with a gritty paste. Electrodes on the face and body are attached using hypoallergenic tape and adhesive pads. Electrodes on the scalp are applied using Collodion glue. *Please be aware that Collodion glue has a strong smell similar to Ether.* This smell is present only during setup and is short lived. The glue is non-irritating and is removed in the morning. 2 bands are applied on the chest and abdomen. One cannula is applied and rests slightly in the nose. One finger clip is attached to the finger. You may have an additional sensor applied to your forearm. This electrode heats up slightly and may leave a very slight red mark. Setup may take an hour or more.

Additional equipment used for testing:

In your room, there is a camera on the ceiling to monitor your positions and movements. There is a microphone and intercom present to communicate with your tech. If you require any assistance during your study, you may simply speak and your tech will respond. Your microphone is always on. Your tech is always available should you need to be disconnected to go to the washroom or if you require an additional blanket, etc.

Testing will last approximately 7 hours. Your tech may enter your room during your study to adjust equipment as necessary.

During your study, your tech may apply a device called CPAP. This is a mask that allows you to breathe properly in your sleep. This may or may not be used during your test. Your tech will explain this in greater detail if it is to be used.

Once the test is complete (between approximately 6-6:45 AM) your tech will enter your room and remove your equipment. There is a short questionnaire to complete. Once this is done you are ready to leave the facility. Check out time is between 6:30-7 AM.

If you <u>MUST</u> cancel your appointment, due to illness or family emergency, please contact the Sleep Disorder Centre as soon as possible.

Due to the fact that we have patients on a waitlist we appreciate as much notice so that we can accommodate another patient.

Contact us…If you have any questions, our phone number is 204-788-8570.

Sleep Disorder Centre
Patient Sleep History

In order that we may process your referral on a timely basis, please ensure that you have completely filled out the following information. Failure to complete each section may result in a delay in providing your appointment.

All data is confidential and no patient identifiers are used.
***Do you consent to this clinical information and/or your sleep study data being used for research purposes? □ Yes □ No**

Today's Date: _____

First Name: _____ Last Name: _____

Date of Birth: ____ _____ _____
dd mm yyyy

<u>Health Card</u>:

MB Health# (6 digit): __ __ __ __ __ __ PHIN# (9 digit): __ __ __ __ __ __ __ __ __

	Yes	No	Number
RCMP	□	□	_____
Canadian Military	□	□	_____
Out of Province	□	□	_____
Aboriginal Treaty	□	□	_____

Do you live on a Reserve? □ **Yes** □ **No**

Home Address/Postal Code: _____

<u>Phone Numbers</u>:

Home#: _____ Cell#: _____ Work#: _____ Message#:_____

Weight: _____ Height: _____

Referring Physician: _____ Family Physician: _____

What are your major concern(s) regarding your sleep? (check all that apply)**:**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Non-refreshing, broken sleep
- ☐ Feeling sleepy during the day
- ☐ Feeling very tired during the day
- ☐ Difficulties breathing in my sleep
- ☐ Snoring and/or stopping breathing bothers my partner
- ☐ Urge to move my legs at night
- ☐ Strange behavior in my sleep (excess movement, sleep walking, etc.)
- ☐ Pain disrupts my sleep
- ☐ Other: _____

Highest Education Level: ☐ High School ☐ Post-Secondary

Type of Occupation: (check any that apply)

- ☐ Drivers who admit they have fallen asleep driving, within the last 2 years
- ☐ Work with Machinery, Hazardous Occupation
- ☐ Commercial Driver
- ☐ Railway Engineer
- ☐ Pilot
- ☐ Air Traffic Controller, Airplane Mechanic
- ☐ Ship Captain
- ☐ Health Care Occupation
- ☐ Child Care Occupation

Evening/Night Shift(s)? ☐ Yes ☐ No

Do you operate heavy/dangerous equipment/transport vehicles (tractor, bus, ambulance)? ☐ Yes ☐ No

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Please answer the following questions as completely as possible.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Using the following scale, circle the *most appropriate number* for each situation:

0 = would *less than once a month* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting, inactive in a public place (in a theatre or in a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon (when circumstances permit)	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in the traffic	0 1 2 3
	Total: _____/24

1) Are your sleep problems affecting your quality of life? ☐ Yes ☐ No

If yes, is this effect: ☐ mild ☐ moderate ☐ severe

Memory Problems? ☐ Yes ☐ No
Problems Concentrating? ☐ Yes ☐ No
Irritability? ☐ Yes ☐ No

2) Because of your sleep problems, have you:

Considered (or are on) disability? ☐ Yes ☐ No
Had work (or school) difficulties? ☐ Yes ☐ No
Had motor vehicle accidents? ☐ Yes ☐ No
Had driving problems? ☐ Yes ☐ No

3) Do you feel rested when you awaken for the day? ☐ Yes ☐ No

4) Do you feel that you are more tired during the day than you should be? ☐ Yes ☐ No

5) Do you get strong urges to fall asleep during the day? ☐ Yes ☐ No

6) Do you fall asleep unintentionally during the day? ☐ Yes ☐ No

If yes, does this occur while you are:

Inactive or bored? ☐ Yes ☐ No
Active or engaged in interesting activities? ☐ Yes ☐ No

7) Do you nap during the day? ☐ Yes ☐ No

If yes: How often? _____ times per day/week/month.
How long? _____ minutes/hours.

Are the naps refreshing? ☐ Yes ☐ No

8) How many nights a week do you have sleep problems? _____ nights.

9) What time do you go to bed during the week? _____ PM/AM.
On the weekend? _____ PM/AM.

10) How long does it take you to fall asleep at night? _____ minutes.

11) What time do you get up during the week? _____ PM/AM.
What time do you get up on the weekends? _____ PM/AM.

12) On average, how often do you wake up during the night? _____ times.
How long does it take you to return to sleep? _____ minutes.

During the <u>past month</u>, how many nights per week did you spend at least one hour awake after falling asleep? ☐ Less than 3 ☐ 3-5 ☐ 6-7

13) How long do you sleep for on an average night? _____ hours.

14) How much sleep do you feel you need? _____ hours.

15) Do you snore? ☐ Do not know ☐ Yes ☐ No
If yes,

A) How often do you snore? (check one)
- ☐ Every night
- ☐ Most (>50%) of nights
- ☐ Some (<50%) of nights
- ☐ Very rarely or not at all

B) How long do you snore? (check one)
- ☐ All night
- ☐ Most (>50%) of nights
- ☐ Some (<50%) of nights
- ☐ Hardly or not at all

C) How audible is your snoring (with the door shut)? (check one)
- ☐ Can be heard down the hall
- ☐ Can be heard in the next room
- ☐ Can be heard in the same room
- ☐ Barely audible

16) Have you awakened during the night choking? ☐ Yes ☐ No

17) Do you ever wake up with an acidic taste in your mouth? ☐ Yes ☐ No

18) Do you ever wake up with your heart racing? ☐ Yes ☐ No

19) On average,
how many times do you get up to go to the bathroom during the night? _____ time(s).

20) Do you awaken in the morning with a dry mouth or cough? ☐ Yes ☐ No

21) Have you gained weight in the last 5 years? ☐ Yes ☐ No
If yes, how much? _____

22) Do you have morning headaches? ☐ Yes ☐ No
If yes, how many days a week? _____ days.

23) Do you have any of the following?

Frequent nasal congestion ☐ Yes ☐ No Tonsillectomy ☐ Yes ☐ No
Blocked nasal passages ☐ Yes ☐ No Nose injury ☐ Yes ☐ No
Previous use of CPAP? ☐ Yes ☐ No False teeth/dentures? ☐ Yes ☐ No
Previous operation for sleep apnea? ☐ Yes ☐ No
Previous use of an oral appliance? ☐ Yes ☐ No

24) Is there a family history of sleep disorders, such as snoring, sleep apnea, narcolepsy, or excessive daytime sleepiness (circle disorder if yes)? ☐ Yes ☐ No

25) Do you take medication or alcohol to sleep better? ☐ Yes ☐ No

26) How many alcoholic drinks do you have on weekdays?_____ on weekends?_____

27) How many caffeine-containing drinks do you consume per day?
____ cups of coffee ____ cola drinks ____ other caffeine drinks

28) Do you smoke? ☐ Yes ☐ No (former smoker) ☐ No (never)
If yes, how much per day? _____ cig./packs.

29) Do you kick during sleep? ☐ Yes ☐ No
Does your body jerk during sleep? ☐ Yes ☐ No

30) Do you have uncomfortable leg sensations (burning, aching, creeping, crawling), that gets worse with rest and better with movement resulting in a need to move your legs? ☐ Yes ☐ No
If yes, do these sensations interfere with your sleep? ☐ Yes ☐ No

This occurs: ☐ every night ☐ 3-5 times/week ☐ 1-2 times/week ☐ less than once/week

31) Have you ever felt "paralyzed" while falling asleep or waking up? ☐ Yes ☐ No

32) Have you ever had vivid dreams or "hallucinations" while falling asleep or waking up? ☐ Yes ☐ No

33) Have you ever collapsed, or lost muscle strength? ☐ Yes ☐ No
If yes, did these episodes come on after experiencing a sudden emotion such as anger, joy or surprise? ☐ Yes ☐ No

34) Do you have nightmares or terrifying experiences at night? ☐ Yes ☐ No

35) Do you talk in your sleep? ☐ Do not know ☐ Yes ☐ No

36) Do you sleep-walk? ☐ Yes ☐ No

37) Has anyone observed you to have unusual movements or behavior in your sleep? ☐ Yes ☐ No

38) Do you eat in your sleep? ☐ Yes ☐ No

Patient Medical History

Have you ever been diagnosed with: (Please √ Yes or No)

				On Medications for:	
A.	High blood pressure?	☐ Yes	☐ No	☐ Yes	☐ No
	Atrial fibrillation?	☐ Yes	☐ No	☐ Yes	☐ No
	Arrhythmia?	☐ Yes	☐ No	☐ Yes	☐ No
	Pacemaker?	☐ Yes	☐ No	☐ Yes	☐ No
	ICD?	☐ Yes	☐ No	☐ Yes	☐ No
	Stroke?	☐ Yes	☐ No	☐ Yes	☐ No
	Shortness of breath?	☐ Yes	☐ No	☐ Yes	☐ No
	Swelling in your ankles?	☐ Yes	☐ No	☐ Yes	☐ No
	Congestive Heart Failure?	☐ Yes	☐ No	☐ Yes	☐ No
	Angina?	☐ Yes	☐ No	☐ Yes	☐ No
	Heart murmur?	☐ Yes	☐ No	☐ Yes	☐ No
	Diabetes?	☐ Yes	☐ No	☐ Yes	☐ No
	High Cholesterol?	☐ Yes	☐ No	☐ Yes	☐ No
	Pre or Post Menopausal?	☐ Yes	☐ No	☐ Yes	☐ No
	Are you pregnant?	☐ Yes	☐ No	☐ Yes	☐ No

Is there a family history of developing heart attacks or strokes in a direct family member less than 50 years of age? ☐ Yes ☐ No

B.	Head injury?	☐ Yes	☐ No		
	Frequent headaches?	☐ Yes	☐ No		
	Epilepsy?	☐ Yes	☐ No	☐ Yes	☐ No
C.	Arthritis?	☐ Yes	☐ No	☐ Yes	☐ No
	Fibromyalgia?	☐ Yes	☐ No	☐ Yes	☐ No
	Do you wake up at night from pain or does it prevent you from falling asleep?	☐ Yes	☐ No	☐ Yes	☐ No
D.	Depression problems?	☐ Yes	☐ No	☐ Yes	☐ No
	Anxiety?	☐ Yes	☐ No	☐ Yes	☐ No
	Panic attacks?	☐ Yes	☐ No	☐ Yes	☐ No
	Psychiatric treatment?	☐ Yes	☐ No	☐ Yes	☐ No
	Alcoholism?	☐ Yes	☐ No		
	Previous Drug Abuse?	☐ Yes	☐ No		
E.	Kidney disease?	☐ Yes	☐ No	☐ Yes	☐ No
	Asthma?	☐ Yes	☐ No	☐ Yes	☐ No
	Emphysema?	☐ Yes	☐ No	☐ Yes	☐ No
	Bronchitis?	☐ Yes	☐ No	☐ Yes	☐ No
	Hypothyroidism?	☐ Yes	☐ No	☐ Yes	☐ No
	Hyperthyroidism?	☐ Yes	☐ No	☐ Yes	☐ No

F. Describe any medical problems not listed on the previous page:

_____

_____

_____

_____

G. List all medicines and pills that you are taking (name/dosage):

_____

_____

_____

_____

_____

_____

H. List any drugs or medicines you are allergic to:

_____

_____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM