UCLA Health System
Sleep Disorders Center
10833 Le Conte Avenue, B Level
Los Angeles, CA 90095
1-310-26SLEEP 1-310-267-5337

MRN:
Patient Name:

(Patient Label)

Welcome to the UCLA Sleep Disorders Center

Welcome to the UCLA Sleep Disorders Center. We are located at 10833 Le Conte Ave, B Level, Los Angeles CA 90095. **Our Sleep Center Website is: http://sleepcenter.ucla.edu**

In order to better care for you, we would like to tell you about our services:

*Enclosed you will find **directions** to the Sleep Disorders Center as well as more information regarding your sleep testing.* In this packet, you will also find materials we are requesting you to complete and bring with you to your appointment. To ensure that the physicians at the UCLA Sleep Disorders Center make an accurate diagnosis and assessment, we need to have this information. This will help us become oriented with any medical or other conditions that may be impacting your sleep.

You are scheduled to arrive at the Sleep Disorders Center no later than 8:30 pm. You may arrive up to 15 minutes prior to your appointment. It is very important that you arrive by 8:30 pm, as you will need to be prepared by the sleep technologists to undergo the sleep test, complete paperwork, be educated about your study and become adapted to the sleep environment. **Any patients arriving past 9pm may need to be rescheduled**. You must call at least 48 hours in advance if you need to cancel your appointment. Please bring your completed questionnaire, insurance card(s), insurance authorization number(s) if applicable, your overnight bag and any medications you will need during your time here. The sleep center will be unable to dispense medications like a pharmacy; therefore you must make sure to bring all of your medications. Please refer to the Facts Sheet included in this packet for more information about your sleep study.

Please complete every page of the attached packet and bring it with you to your appointment.

Insurance: *Please contact your insurance representative to determine your coverage. Your carrier will be billed for your appointments; however, any charges not covered or remaining balances will be your financial responsibility. Authorizations must be processed before we may give you an appointment. Inform your insurance carrier that you will be undergoing an outpatient sleep study. Although you will be spending the night in our sleep laboratory, this is an outpatient study.*

Our department has earned an outstanding reputation in subspecialty care of sleep disorders due to a high level of clinical expertise, academic achievement and innovative research. Our most important mission is to provide each patient with the best sleep medicine health care available by combining our extensive experience with the latest advances in the treatment of sleep disorders. Our faculty and staff work together as a team to bring each patient the highest quality of care in a warm, friendly and professional environment.

We look forward to caring for you.

Sleep Center Staff

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Directions from 405 Freeway

- Take Wilshire Blvd East exit
- Turn left at Westwood Blvd
- Turn right at Le Conte Ave (at the Chick-fil-a)
- Turn left on Tiverton Ave (just after Ralph's) *and follow the parking directions below*

Directions from Downtown

- Take the 10 Freeway West towards Santa Monica
- Exit on to the 405-N
- Take the Wilshire Blvd East exit
- Turn Left at Westwood Blvd
- Turn right at Le Conte Ave (at the Chick-fil-a)
- Turn left on Tiverton Ave (just after Ralph's) and follow the parking directions below

Parking Directions

- Enter the CHS Parking Structure on the left.
- Upon entering parking structure take a right to Patient and Visitor parking (***You will go up one level and then down one level to Patient and Visitor Parking)***
- Please follow the **Orange** Patient and Visitor signs to designated Sleep Center Parking on the A level of the CHS parking structure. Make sure you place the Parking Pass face up on your dashboard.
- Once parked there will be a **Yellow Line** on the ground. Please follow this line into the building. This line will take you to the elevators and you will proceed *down* to the B level.
- When you exit the elevator you will continue to follow the **Yellow Line** to the Sleep Center.
- If you get lost, call 310-267-1038 or 310-267-0444
- Please See Attached Map for Designated Parking Spaces

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How to Prepare and What to Bring

How to Prepare

- Please shower and wash your hair BEFORE coming to the Sleep Lab
- We do not recommend having your hair done before coming to the lab
- Do not use hair spray or oils in your hair
- Keep makeup to a minimum. (This will ensure better adhesion of electrodes.)
- Smoking is NOT allowed.
- You are expected to arrive at your scheduled time. Please plan for traffic.
- Our sleep center technologists do not arrive until 8pm.

Items to Bring

- Medications
  - If you take medications before bedtime, bring them with you.
  - Technologists may not administer any medications.
- Pajamas or a two piece outfit to wear to sleep
- Toiletries (toothbrush, toothpaste, contacts solution, etc.)
- Shoes, slippers or sandals to go to the bathroom
- Favorite pillow: We have pillows, but you are welcome to bring a comfort item from home
- Sleep Questionnaire (attached)
- If you wear a CPAP or BiPAP mask at home, you may bring it with you.
- If you use a dental device to treat sleep apnea, please bring it with you.

For patients scheduled for additional recordings the following day:

Breakfast and lunch facilities are available, but are at cost to the patient.
Please bring enough money for these meals.
If bringing food from home, you may bring a lunch-sized cooler or we have a refrigerator you may use.
We do have a microwave; please ask for assistance.

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What to Expect During Your Study

Our staff will be doing everything possible to make your nights stay in the Sleep Center as comfortable as possible. The application of electrodes is painless and safe. We will be monitoring your brainwaves, breathing, heart rhythm, oxygen saturation and muscle movements. Wearing the electrodes and sensors may disturb your sleep somewhat. This is normal. Your cooperation and patience is appreciated for this important test.

- You will check in with the technologists and will be shown to your room.
- We may need to collect any additional information needed for your specific study and the questionnaire if not completed in advance.
- Small gold-cupped wires (electrodes) will be filled with cream and taped to or near your chin, ears, head, chest, legs and near your eyes. This takes about one hour, and will begin between 8:45pm and 10:00pm.
- All electrodes and sensors are placed using hypoallergenic tape. Please let us know if you have a known skin allergy.
- In some cases, after the study has begun, a technologist may need to re-enter your room to reposition sensors or to begin CPAP treatment.
- The technologists are awake all night and you may call them if you need them.
- You will be on a video monitor throughout the night. Recordings are used by Sleep Specialist Physicians only. Recordings are not available for transfer or copy.
- The lab technologist who removes the electrodes in the morning may not be the same technologist who applied the electrodes the night before.
- Except for going to the bathroom, you must stay in bed throughout the night, resting quietly if you are awake.
- The technologists are highly trained and knowledgeable; however, they may not give you any information regarding your sleep study results or medical condition(s).
- Results will be available in 10 working days or less, and may be discussed in detail with your physician.
- Sleep study reports are sent to the referring physician(s) only. If you wish to obtain a copy of your report, please contact the Medical Records Department at 310-825-6022.
- Sleep recordings are highly specialized medical procedures that require time and care in performing and analyzing. Please try to cooperate with technologists requests as best you are able.
- Checkout: You will be able to leave by 6:00AM the following morning if not scheduled for additional recordings. Some individuals wish to wash their hair after returning home.
- Accommodations: While we strive to make this experience as comfortable as possible, please be advised that this is a hospital-based facility. Our beds are single hospital beds, complete with bedrails to provide extra safety for our patients. Each room has its own sink, mirror, and television for your convenience. However, we ask that you turn the television off during the recording of your sleep study. Earplugs, towels, extra blankets, and drinking water are available upon request.

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PATIENT INFORMATION

Last, First, Middle Name:			Today's Date:
Age:	Birth Date:	Sex:	Native Language:
		Male / Female	
Referring Physician's Full Name:			Telephone #:
Physician's Address:			
Are you:	Right-handed Left-handed Ambidextrous		
Height:		Weight	
What is/are your specific sleep difficulties?			

Past Medical History:	Date Diagnosed:

Hospitalizations, Operations and dates.

Injuries and dates. Include any episodes of loss of consciousness.

Blood Transfusions and dates.

Drug Allergies and reactions:

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Medications (current and/or recent)

Name	Dosage	How often?

(*Attached typed sheet/write on back if necessary)

Dietary Supplements/Vitamins:

Name	Dose & Frequency

Social History

Any use of tobacco (type and for how long)? _____

Any use of caffeinated beverages? _____

Any use of alcohol (type and for how long)? _____

Any use of recreational drugs (type and for how long)? _____

Any exposure to toxins/poisonous substances at work or with hobbies? _____

_____

What type of work do you do? _____

Education: Grade School High School College Post-Graduate Voc. Training

Marital Status: Single Married Divorced Separated Widowed

Birthplace: _____

_____

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FAMILY HISTORY

Mother: Living or deceased? Age: _____
Health Problems: _____

Father: Living or deceased? Age: _____
Health Problems: _____

Brothers/Sisters: List from the oldest to youngest.

1. Brother or sister? Living or deceased? Age: _____
   Health problems: _____
2. Brother or sister? Living or deceased? Age: _____
   Health problems: _____
3. Brother or sister? Living or deceased? Age: _____
   Health problems: _____
4. Brother or sister? Living or deceased? Age: _____
   Health problems: _____

Children: List from oldest to youngest.

1. Daughter or son? Living or deceased? Age: _____
   Health problems: _____
2. Daughter or son? Living or deceased? Age: _____
   Health problems: _____
3. Daughter or son? Living or deceased? Age: _____
   Health problems: _____

Has any of your family or relatives had the following health conditions? If yes, whom?

Heart disease		Stroke	
High blood pressure		Fainting	
High cholesterol		Diabetes	
Loss of memory		Cancer	
Epilepsy/seizures		Multiple sclerosis	
Depression		Polio	
Mental disease		Limping	
Muscle weakness		Thyroid disease	

Other: _____

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REVIEW SYSTEMS

Please place a checkmark if you currently have any of the following symptoms.

1. "constitutional"	☐ fever	☐ weight loss	☐ fatigue
2. "eyes problem"	☐ blurred vision ☐ eye pain	☐ double vision ☐ eye redness	☐ loss of vision ☐ eye dryness
3. "ear/nose/throat"	☐ trouble hearing ☐ loss of balance ☐ hoarseness	☐ ringing in ear(s) ☐ ear pain ☐ trouble swallowing	☐ dizziness (vertigo) ☐ ear discharge ☐ slurred speech
4. "cardiovascular"	☐ chest pain ☐ limb swelling	☐ irregular heart beat ☐ limb pain on walking	☐ fast heart beat ☐ fainting
5. "respiratory"	☐ trouble breathing	☐ chronic cough	☐ coughing blood
6. "gastrointestinal"	☐ indigestion ☐ nausea ☐ diarrhea	☐ heart burn ☐ vomiting ☐ constipation	☐ abdominal pain ☐ regurgitation ☐ bloody stools
7. "genitourinary"	☐ incontinence	☐ pain on urination	☐ blood in urine
8. "musculoskeletal"	☐ muscle pain ☐ loss of muscle bulk ☐ joint pain	☐ muscle cramp ☐ neck pain ☐ joint stiffness	☐ muscle twitches ☐ back pain ☐ joint swelling
9. "skin & breast"	☐ numbness	☐ tingling	☐ discoloration
10. "neurologic"	☐ headache ☐ weakness ☐ blackouts	☐ face pain ☐ tremors ☐ trouble with memory	☐ face numbness ☐ clumsiness ☐ trouble concentrating
11. "psychiatric"	☐ hallucinations ☐ suicidal thoughts	☐ feeling depressed ☐ inappropriate crying	☐ trouble sleeping ☐ inappropriate laughing
12.	☐ abnormal bleeding	☐ nose bleeds	☐ lumps or swellings
13. "allergic/immunologic"	☐ skin rash	☐ joint pain	☐ dry eyes & or dry mouth
14. "endocrine"	☐ excessive thirst	☐ heat or cold intolerance	☐ excessive urination

Person completing questionnaire _____ Relationship to patient: _____

For office use: This questionnaire may be completed by the patient, relative or ancillary staff provided that it is signed and dated by the treating physician. (Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent charges.)

++

Physician's Signature: _____ Date: _____ Time: _____

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OUTPATIENT NOTES
UCLA Sleep Disorders Center

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NAME: _____ **GENDER:** ☐ Male ☐ Female **AGE:** _____

MARITAL STATUS:

☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated ☐ Living together

OCCUPATION: _____

SLEEP QUESTIONNAIRE

My main sleep complaint is:

☐ Trouble sleeping at night ☐ Being sleepy all day

☐ Unwanted behaviors during sleep, explain: _____

_____

☐ Other (explain): _____

USUAL SLEEP HABITS:

Bedtime: _____ ☐ am ☐ pm Number of awakenings: _____

Wake time: _____ ☐ am ☐ pm Number of naps/week: _____

Duration of sleep problem: _____

DIRECTIONS: Check any statement which **currently** applies to you:

☐ unrefreshing naps
☐ dream a lot
☐ was a hyperactive child or teenager
☐ use sleeping pills
☐ bed partner disturbs sleep
☐ heart pain during the night
☐ awaken with back pain
☐ restless sleeper
☐ trouble falling asleep
☐ awaken long before it is necessary
☐ sleep better in unfamiliar setting
☐ light sleeper
☐ trouble returning to sleep
☐ stop breathing during sleep
☐ gained more than 10 lbs in the last year
☐ unable to sleep in a flat position
☐ jaws ache in morning
☐ bitter or sour mouth taste in morning
☐ very loud snorer
☐ awaken with headaches
☐ have high blood pressure
☐ awaken with choking sensation
☐ driving accidents or near-accidents due to sleepiness
☐ paralysis or inability to move on awakening
☐ driven miles past destination with little awareness
☐ falling asleep at inappropriate times
☐ refreshing naps
☐ dreams or hallucinations while awake
☐ sudden feeling of weakness in knees or legs
☐ difficulty waking up in the morning
☐ function best in the evening
☐ don't feel tired at bedtime
☐ shift-worker or night work
☐ experience restlessness, tingling, or crawling in legs
☐ sleep talking as adult
☐ banging, twisting or shaking head in sleep
☐ sudden awakening with intense anxiety or dread
☐ grind teeth in sleep
☐ sleepwalking as an adult
☐ bedwetting in adulthood
☐ awaken with heartburn
☐ cough up sputum or mucus at night
☐ kicking or twitching during sleep
☐ legs jerk during sleep
☐ experience inability to keep legs still
☐ nocturnal seizures
☐ bitten tongue during sleep

WOMEN

☐ sleep problem varies with menstrual cycle
☐ sleep problem started or got worse at menopause
☐ currently taking hormonal pills

MEN

☐ awaken with painful penile erections
☐ have problems obtaining or maintaining erections

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SPOUSE or ROOMMATE QUESTIONNAIRE

TO BE COMPLETED BY BEDPARTNER, FAMILY MEMBER OR ROOMMATE

Check any of the following behaviors that you have observed the patient do while he/she is asleep:

- ☐ loud snoring
- ☐ light snoring
- ☐ twitching of legs or feet during sleep
- ☐ pause in breathing
- ☐ grinding teeth
- ☐ sleep talking
- ☐ sleep walking
- ☐ pause in breathing
- ☐ bed wetting
- ☐ sitting up in bed but not awake
- ☐ head rocking or banging
- ☐ kicking with legs during sleep
- ☐ getting out of bed but not awake
- ☐ biting tongue
- ☐ becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) checked above?

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, its frequency during the night, and whether it occurs every night.

If you heard loud snoring, do you remember hearing short pauses in the snoring or occasional loud "snorts"? ☐ Yes ☐ No

Describe:

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EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale (ESS) is a standardized a self-administered 8-item questionnaire commonly used to assess sleepiness. [29]

Patients are given the following instructions:

The questionnaire asks you to rate the chances that you would doze off or fall asleep during different routine situations. Answers to the questions are rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high likelihood that you would doze or fall asleep in that situation.

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

	Chance of Dozing			
Situation	**Never (0)**	**Slight (1)**	**Mod (2)**	**High (3)**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive, in a public place *(e.g. a theater or 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	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

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DAILY SLEEP LOG

To help us understand your sleep problems, we need a report of the times when you sleep, nap and wake-up during sleep. In addition, we need to know the times when you drink coffee, tea and alcoholic beverages. If medication is taken, record the time medication is needed. It is important that you keep this record for 7 days. Each column begins with a new day. The first column is an example for you to study. If you have any questions, call the UCLA Sleep Disorders Center. "A" indicates AM (morning), "P" indicates PM (afternoon or evening).

DATE: ***Please be sure to write the date***	**Example: 10/7**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**	**Day 7**
Bedtime	11:00 PM							
Estimated time it took to fall asleep	45 min.							
Time of awakenings during sleep and length of time you were awake	2 A – 1 hr 3 A – 1 hr							
Time of final awakening in the morning	5:30 AM							
Total night's sleep	3 hrs							
Naps, times you napped, & length of naps	2 P 45 min.							
Medications taken, times and amounts	(i.e Zolpidem, 10mg) 10:30 PM							
Coffee and tea, number of cups and time drank	7:00 A - 1							
Alcoholic drinks, number and time drank	8:00 P – 1 9:00 P – 1 10:00 P – 1							

Evening activities for each day:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

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Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than Half the days	Nearly Every day
1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed, or hopeless:	0	1	2	3
3. Trouble falling asleep, staying asleep… or sleeping too much:	0	1	2	3
4. Feeling tired or having little energy:	0	1	2	3
5. Poor appetite or overeating:	0	1	2	3
6. Feeling bad about yourself: (That you are a failure or have let yourself or your family down)	0	1	2	3
7. Trouble concentrating (Reading the news or watching TV):	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you'd be better off dead or hurting yourself:	0	1	2	3
Score:	____	____	____	____

How difficult have the above problems made it for you to do your work, take care of things at home, or get along with other people?

1. Not difficult at all: __ 2. Somewhat difficult: __ 3. Very difficult: __ 4. Extremely difficult: __

Total PHQ-9 Score: ____