Ridgeview SLEEP DISORDERS CENTER

HOME SLEEP TEST
HSAT (Home Sleep Apnea Test)

Thank you for choosing Ridgeview for your health care needs! Our goal is to provide the best possible health care for the community we serve. This letter is to confirm your scheduled sleep study and to explain what is involved with the procedure.

Prior to your arrival, please review the following information about the Sleep Center. Fill out the forms included in this packet.

REMINDERS FOR THE DAY OF YOUR APPOINTMENT:

- Please plan on returning your home sleep kit to the Home Sleep Test Drop Box at the Sleep Center in Ridgeview Medical Place by **1:00 PM** on the day following your sleep test.
  Please call 952-442-8012 to reschedule your sleep test if you are unable to return the kit by **1:00 PM** on the following day.
- Bring your medication list and the completed health questionnaires.
- Arrive at the time you were scheduled for. If you cannot keep this time, please contact the sleep center prior to your appointment.
- The Ridgeview Medical Place building is locked at night, park on the front (north side) of the building and ring the buzzer to the left of the door under the larger canopy. (Refer to map in packet.)

If you should need to cancel or reschedule your sleep study, please contact our scheduling office as soon as possible at 952-442-8012 from 8am-4:45pm so we are able to fill that opening with another patient.

If you have any questions or concerns or need additional information about the Sleep Test, you may call the Sleep Center at 952-442-8080.

Ridgeview SLEEP DISORDERS CENTER

Home Sleep Apnea (HSAT) Test Information

Your sleep test is scheduled for_____ at _____.

Address of the SLEEP CENTER: *(on the north side of the hospital)*

RIDGEVIEW SLEEP CENTER
RIDGEVIEW MEDICAL PLACE
490 South Maple St., Suite 103
Waconia, MN 55387
Parking: Park in the area marked Entrance.

(See map in packet for both building locations)

The follow up appointment to go over test results is scheduled for _____
****PLEASE NOTE: YOUR FOLLOW UP APPOINTMENT IS LOCATED IN THE:**
(on the south side of the hospital)

RIDGEVIEW PROFESSIONAL BUILDING
560 S. Maple Street, Suite 400
Waconia, MN 55387

The entrance doors of the Sleep Center will be locked when you arrive for your sleep test. **YOU MUST RING THE BUZZER TO NOTIFY THE STAFF OF YOUR ARRIVAL.** The sleep technician will then greet you at the front door and escort you to your private room in the Sleep Center.

If you have been scheduled for a home sleep test, please read the following information, which will explain what is involved with the procedure.

Benefits/Limitations of a Home Sleep Test
While a Home Sleep Apnea Test (HSAT) offers the benefit of performing the test from your home, a HSAT is not indicated for every patient that may have a sleep disorder as it actually does not measure sleep. The Home Sleep Apnea Test is specifically indicated for patients that are at a high risk for a condition known as Obstructive Sleep Apnea (OSA). OSA is a condition characterized by loud snoring, excessive tiredness and repetitive breathing pauses. HSAT uses a limited number of sensors to detect this condition and is unable to detect any other sleep disorders. At times, sensors may become dislodged while you sleep resulting in inadequate recordings.

Traditionally, these patients have been tested by complete laboratory testing, where a technologist monitors for all sleep disorders, assures that all of the recording equipment functions correctly and begins treatment as directed by a physician.

In some cases, you may require complete laboratory sleep testing if one of the following occurs:

- The HSAT results are in normal ranges, but your symptoms suggest otherwise.
- If you have difficulty with treatments that are prescribed following the HSAT.
- Additional Sleep Disorders are suspected.

If you have any questions or concerns about the testing procedure, feel free to call the Sleep Center at 952-442-8080. If no one is available, please leave a message and we will return your call.
If you should need to cancel or reschedule your sleep study, please contact our scheduling office as soon as possible at 952-442-8012 from 8am-4:30pm.

Information about the testing procedure
When you arrive at the Sleep Center for your appointment, the technologist will instruct you on how to apply several recording sensors connected to a portable data recorder that will be used from the comfort of your own home. The accuracy of the test can be affected by where you apply the recording sensors or if they become dislodged during the test so it is important that you ask any questions you may have during the instruction period. An instruction sheet is provided to show you where the electrodes are to be placed and the Sleep Center Technologists are available throughout the night to assist you if issues arise with the device.

Please contact them at **952-442-8080** if you feel you need assistance.
Please call 911 for any emergencies.

The technologist will show you how to place a sensor that will be used to record your breathing pattern. Two elastic bands will be placed around your chest and abdomen to record your breathing effort. Next, a sensor will be placed over one fingernail so we ask that you have one finger (non-pinky) on each hand free of fingernail polish and/or acrylic nails. Finally, three electrodes will be placed on your chest to record your heart rate. The sensors and bands do not hurt, but initially may be distracting. During the recording, the sensors will be connected to a recording box attached to your shirt. You will be able to get up and use the bathroom if needed during the test.

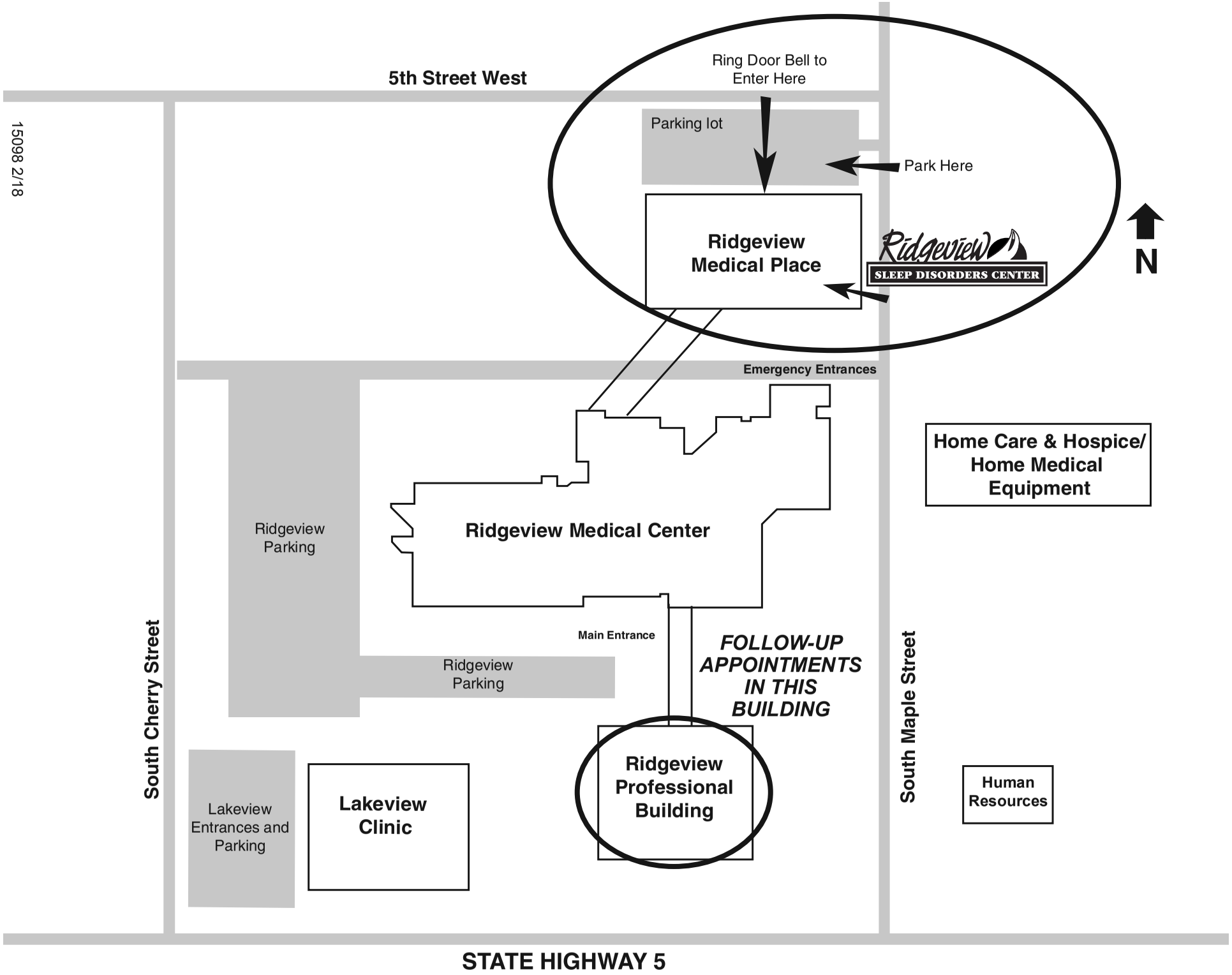
After completing the test, you will need to return the device to the sleep center by noon on the day following your sleep test so that we are able to download and review the recordings for interpretation. You will schedule a follow-up appointment with the sleep specialist to receive the results.

On the day of your scheduled sleep study:
- Avoid naps
- Avoid caffeine after 10 a.m. (beverages and chocolate)
- Avoid alcohol
- If you have a cold, please contact us. We may want to reschedule your sleep test.
- Plan to bring the recording device back the day following your test to the Home Sleep Test Drop Box.

Address of the Sleep Center:
Ridgeview Medical Place, 490 S. Maple Street, Suite 103, Waconia, MN 55387

The entrance doors will be locked when you arrive. **YOU MUST RING THE BUZZER TO NOTIFY THE STAFF OF YOUR ARRIVAL**. The sleep technologist will then greet you at the front door and escort you to the Sleep Center to provide instructions on the use of the recording equipment.

NOTE: You will receive two separate bills related to your visit to the Sleep Center - one from Ridgeview Medical Center for the home sleep test itself and one from Ridgeview Clinics for Dr. Vaela's professional interpretation of the test. If you have any questions, please do not hesitate to ask the sleep staff.


15098 2/18
5th Street West
Ring Door Bell to Enter Here
Parking lot
Park Here
Ridgeview Medical Place
Ridgeview SLEEP DISORDERS CENTER
N
Emergency Entrances
Home Care & Hospice/ Home Medical Equipment
Ridgeview Parking
Ridgeview Medical Center
Main Entrance
FOLLOW-UP APPOINTMENTS IN THIS BUILDING
Ridgeview Parking
South Cherry Street
South Maple Street
Lakeview Entrances and Parking
Lakeview Clinic
Ridgeview Professional Building
Human Resources
STATE HIGHWAY 5

Ridgeview SPECIALTY CLINIC

Pulmonary & Sleep Medical Information

Name _____

Date of Birth _____

or Patient Label

Age: _____ Ht. _____ Wt. _____

Referring Provider/Location: _____

Primary Care Provider/Location: _____

Preferred Pharmacy/Location: _____

Instructions: Please complete as much as possible of the information requested below before coming to your appointment. This information is, and will be kept, strictly confidential. It will help your physician understand all your medical problems and prior history better, which is essential to providing good medical care.

Reason for visit: _____

PAST MEDICAL HISTORY: Please indicate if you have been diagnosed as having any of the illnesses below. Enter approximate year of initial diagnosis if you remember.

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Emphysema or COPD				Hypertension (high blood press.)				Diabetes			
Chronic Bronchitis				Heart Attack				Blood Clots (legs or lungs)			
Asthma				Angioplasty				Stroke			
Tuberculosis				Heart Failure				Cancer (enter organ below)			

Past Surgical History: List all previous surgeries and year done. _____

_____

_____

Allergies: Please list allergies to any medications. If you are allergic to X-ray contrast, please indicate so also. _____

_____

_____

Medication List (or attach Medication List): _____

_____

_____

SOCIAL HISTORY: **Any concerns for your safety?** _____

Smoking History: **current / former / never** Packs per day? _____ How many years? _____ Quit (year): _____

Vape use? _____ Smokeless Tobacco use? _____ Second-hand Smoke Exposure? _____

Alcohol Consumption: What type? _____ How often? _____

Caffeine Consumption: What type? _____ How often? _____

Pets/birds? _____

FAMILY HISTORY: Please indicate if the illnesses below are present in your **immediate family** (parents, brothers or sisters).

Illness	X	Relative affected
Diabetes		
Heart Attack		
Lung Cancer		

Illness	X	Relative affected
Emphysema or COPD		
Asthma		
Stroke		

OCCUPATIONAL HISTORY: What type of work do you currently do? _____

Have you worked with asbestos, silica or coal in the past? _____ When? _____

IMMUNIZATIONS:

Flu Vaccine?	Pneumonia Vaccine?

OVER →

Place a checkmark if you are bothered by any of the following symptoms frequently or constantly:

	Yes	No	Physician's Comments:
Constitutional			
Fever?	_____	_____	
Weight loss or weight gain?	_____	_____	
ENT			
Congestion of nose?	_____	_____	
Frequent "runny" nose?	_____	_____	
Post nasal drip?	_____	_____	
Hoarseness?	_____	_____	
Pulmonary/Sleep			
Wheezing?	_____	_____	
Shortness of breath at rest?	_____	_____	
Shortness of breath with activities?	_____	_____	
Cough?	_____	_____	
Sputum or phlegm production?	_____	_____	
Snoring?	_____	_____	
Sleepy during the day?	_____	_____	
Cardiac/Vascular			
Chest pain with exertion?	_____	_____	
Leg cramps with walking?	_____	_____	
GI			
Nausea and/or vomiting?	_____	_____	
Frequent heartburn?	_____	_____	
Bloody or tarry stools?	_____	_____	
Change in bowel habits?	_____	_____	
GU			
Up frequently at night to urinate?	_____	_____	
Trouble urinating?	_____	_____	
Muscular/Skeletal			
Pain in joints or elsewhere keeping you from sleeping?	_____	_____	
Neurologic			
Frequent headaches?	_____	_____	
Sudden loss of vision?	_____	_____	
Blood/Lymph			
Easy bruising?	_____	_____	
Enlarged lymph nodes?	_____	_____	

Below for Physician's use only.

Other symptoms are negative?	_____	_____	

Reviewing Physician's signature _____ Date _____

Please complete the questions below as accurately as possible.
When appropriate, fill in blanks, check, underline or circle best answer.

1. If you are currently employed, what shift do you work? [ ] 1st [ ] 2nd [ ] 3rd [ ] Rotating
2. What time do you go to sleep? _____
3. What time do you wake up? _____
4. How many times do you awaken during your sleep? _____ Why? _____
5. Do you feel rested when awakening? [ ] Yes [ ] No
6. Do you nap during the day? [ ] Yes [ ] No
7. If you do nap, estimate frequency: [ ] daily _____times per week [ ] rarely
8. If you do nap, how long is your typical nap? _____
9. Do you perspire during sleep? [ ] Yes [ ] No
10. Do you snore? [ ] Yes [ ] No If yes, for how long? _____ years and/or _____ months
11. Has your bed partner ever said you stop breathing during sleep? [ ] Yes [ ] No
    If yes, for how long? _____ years and/or _____ months
12. Do you ever awaken from sleep "gasping" for breath or "choking"? [ ] Yes [ ] No
13. Do you often feel sleepy during the day? [ ] Yes [ ] No
    If yes, for how long? _____ years and/or _____ months
14. Have you ever fallen asleep driving a vehicle (or nearly so)? [ ] Yes [ ] No
15. Ever had a car or work accident because of sleepiness? [ ] Yes [ ] No
16. Do you fall asleep easily during quiet activities (reading, TV, etc.)? [ ] Yes [ ] No
17. Are you often tired during the day? [ ] Yes [ ] No If yes, for how long? _____ years and/or _____ months
18. Is your sleep restless? [ ] Yes [ ] No
19. Have you ever had a sudden "irresistible" sleep attack? [ ] Yes [ ] No
20. Do you ever suddenly feel very weak when laughing, sad, angry or otherwise excited (in the knees, neck, arms or all over)? [ ] Yes [ ] No
21. Do you ever feel you cannot move (for a brief period) just as you are falling asleep or when awakening? [ ] Yes [ ] No
22. Do you think you hallucinate when falling asleep or awakening? [ ] Yes [ ] No
23. Do you often experience confusion or poor memory during the day because you are too sleepy or tired? [ ] Yes [ ] No

Ridgeview Sleep Disorders Center

DAYTIME SLEEPINESS QUESTIONNAIRE

OVER →

3PQ

Name _____ Age: _____ Gender: [ ] Male [ ] Female

Epworth Sleepiness Scale

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. 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**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____

Thank you for your cooperation.

Ridgeview Sleep Disorders Center

DAYTIME SLEEPINESS QUESTIONNAIRE

#15067 1/2007 (Side 2)