KAISER PERMANENTE®

The Permanente Medical Group, Inc.
Sleep Medicine Department
401 Bicentennial Way, MOB East 190
Santa Rosa, CA 95403
707-393-4008

Sleep Study Test Information

You have been scheduled for a Sleep Study in our Sleep Medicine Clinic. Please follow the instructions carefully, to ensure the test results are accurate. If you are unable to complete the instructions for your scheduled appointment, please call our department and we can reschedule your appointment for a time that works for you.

Things to know before your Sleep Study Test appointment:

1. You have been scheduled for a home sleep study. You will come to your scheduled appointment, learn how to wear the testing equipment, and take the equipment home and wear it for one night while you are sleeping.
2. The test equipment must be returned by 9:00 AM the next day. If you are unable to do so, please call 707-393-4008 to reschedule the appointment.

Instructions for your Sleep Study Test:

1. No artificial nails/gels and nail polish are allowed on the index finger and ring finger of your non-dominant hand. Example, if you are right handed, it would be your fingers on your left hand that need to be free of artificial nails/nail polish.
2. Please arrive at MOB East Suite 190 ten minutes before your scheduled appointment. The appointment is 30-45 minutes. If you cannot keep your appointment, call 707-393-4008 to reschedule.
3. Bring the equipment by 9:00 AM the following day.
    a. Before 8:20 AM: please return the equipment to the Security Desk in the Emergency Department.
    b. After 8:20 AM: please return the equipment to MOB East Suite 190.

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EPWORTH SLEEPINESS SCALE

Complete and bring with you to your appointment. Complete both sides of form.

Patient Name: _____ Date: _____

Medical Record #: _____

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Check the most appropriate number for each situation.

Situation	No chance 0	Slight chance 1	Moderate chance 2	High chance 3
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive in a public place	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car while stopping for traffic	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐

Have you ever had a sleep study? ☐ Yes ☐ No
If yes, When? _____ Where? _____

Please answer a few additional questions:

How many cups of coffee do you drink each day?	_____	At what time(s)?	_____
How many cans of soda do you drink each day?	_____	At what time(s)?	_____
How many alcoholic beverages do you drink each day?	_____	At what time(s)?	_____
How many cups of non-herbal tea do you drink each day?	_____	At what time(s)?	_____
How many packs of cigarettes do you smoke each day?	_____	At what time(s)?	_____

Please list any recreational drugs that you may take: _____
Please list any other treatments for sleep problems you have tried in the past:
_____
_____

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SLEEP BEHAVIOR QUESTIONNAIRE

Patient: Please complete this page yourself based upon what you have been TOLD about your sleep behaviors.

Patient Name: _____ Date: _____

Medical Record #: _____

Check any of the following behaviors that patient has been observed doing while he/she were asleep.

- ☐ Loud snoring
- ☐ Light snoring
- ☐ Sleep talking
- ☐ Sleep walking
- ☐ Head rocking or banging
- ☐ Becoming very rigid and/or shaking
- ☐ Twitching of legs or feet during sleep
- ☐ Sitting up in the bed but not awake
- ☐ Gasping for air
- ☐ Pause in breathing
- ☐ Biting tongue
- ☐ Bed wetting
- ☐ Grinding teeth
- ☐ Kicking with legs during sleep
- ☐ Getting out of bed but not awake

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 which it occurs, its frequency during the night, and whether it occurs every night.

_____
_____
_____

If you heard snoring, do you remember hearing short pauses in the snoring or occasional loud "snorts"? _____

Please include any other additional information that may be useful to the doctor:

_____
_____
_____
_____