###### Premier Sleep Diagnostic Center

**5292 Lyngate Ct, Burke VA 22015**

**PHONE: +1 (703) 992-0803 | FAX: +1 (703) 204-0356**

###### PATIENT LETTER

**Date: - / - / -**

**RE: Sleep Study**

**Dear:**

Your referring physician has arranged for a sleep evaluation with ***Premier Sleep Diagnostic Center*** , located at **5292 Lyngate Court Burke, Virginia - 22015. Please see attached map for specific directions**.

**Your sleep study appointment is schedule on \_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_, 2021 @ : AM/PM**

Please fill out the attached paperwork prior to your scheduled appointment. If this is your first sleep study at our facility, please complete the entire package. Please remember to bring your completed “Sleep Questionnaire” with you to your appointment. Also, if you were provided a prescription from referring physician, please bring with you as well.

**In addition, please remember to bring your Insurance Card and a Photo ID, as well. Please bring an insurance referral from your Primary Care Physician, if your insurance requires that you do so for a specialist.**

Please do not arrive earlier than your scheduled appointment time, as the technologist will not be available or ready until then.

We look forward to serving you and hope to accommodate you in a most courteous and professional manner.

If we may provide any additional information, please call us at **703-992-0803** in day time, **540-222-9581 to reach the Office manager in case of after hour assistances.**

*Sincerely,*

**Management**

Premier Sleep Diagnostic Center

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| 1. Have you ever had allergies, asthma, hay fever, eczema or problems with rashes? | ❑ | ❑ |
| 1. Have you ever had anaphylaxis or an unexplained reaction during a medical procedure? | ❑ | ❑ |
| 1. Have you ever had swelling, itching or hives on your lips or around your mouth after blowing up a balloon? | ❑ | ❑ |
| 1. Have you ever had swelling, itching or hives on your lips or around your mouth during or after a dental examination or procedure? | ❑ | ❑ |
| 1. Have you ever had swelling, itching or hives following a vaginal or rectal examination or after contact with a diaphragm or condom? | ❑ | ❑ |
| 1. Have you ever had swelling, itching or hives on your hands during or within one hour after wearing rubber gloves? | ❑ | ❑ |
| 1. Have you ever had a rash on your hands that lasted longer than one week? | ❑ | ❑ |
| 1. Have you ever had swelling, itching or hives after being examined by someone wearing rubber or latex gloves? | ❑ | ❑ |
| 1. Have you ever had swelling, itching or hives, running nose, eye irritation, wheezing or asthma after contact with any latex or rubber product? | ❑ | ❑ |
| 1. Has a physician every told you that you have rubber or latex allergy? | ❑ | ❑ |
| 1. Are you allergic to bananas, avocados, chestnuts, pears, fig, papaya or passion fruit? | ❑ | ❑ |
| 1. Are you presently on beta blockers? | ❑ | ❑ |

**LATEX ALLERGY- PATIENT QUESTIONNAIRE**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**No Show ---- Cancellation --- Late Fee Policy**

There is a **$150.00**charge for appointments that are not kept or cancelled with less than a 24 hour notice before your scheduled sleep study appointment. If you show up late for your

scheduled appointment, you may be turned away and be charged as well. Please feel free to contact us at +1 (703) 992-0803 should the need arise.

Your health insurance will **NOT** pay for this fee. You will be the responsible party.

This policy is instituted as part of our sleep center’s goal to provide superior care for

our valued patients. We have many patients in need of sleep testing and a highly qualified sleep technologist is scheduled in advance for your specified sleep testing needs. *It is essential that you let us know immediately if you are unable to keep your appointment.*

Your signature below acknowledges that you have received notice of this policy and will be responsible for canceling in advance as well as any charges resulting from non-compliance to this policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness By: Date

**PATIENT REGISTRATION FORM**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT NAME LAST FIRST MIDDLE** | | | | | | **DATE OF BIRTH** | |
| **HOME ADDRESS** **APT. NO**. **CITY** | | | **STATE** | | | **ZIP CODE** | |
| **OCCUPATION** EMPLOYED RETIRED STUDENT | **SOCIAL SECURITY #** | **MARITAL STATUS**  S M D W | | **SEX**  M F | **HOME PHONE** | |
| **EMPLOYER** | **E – MAIL ADDRESS** | | | | **WORK PHONE** | |
| **CELL #** | |
| **SPOUSE (OR PARENT) NAME** | **SPOUSE (OR PARENT) EMPLOYER** | | | | **SPOUSE / PARENT WORK PHONE:** | |
| **EMERGENCY CONTACT: EMERGENCY CONTACT PHONE:** | | | | | | | |

**PRIMARY INSURANCE INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SUBCRIBER’S FIRST NAME LAST NAME** | | **RELATIONSHIP TO PATIENT** | | **DATE OF BIRTH** |
| **PRIMARY INSURANCE COMPANY NAME** | | **SOCIAL SECURITY # SPOUSE:** | | |
| **ADDRESS** | | | | |
| **CITY** | **STATE** | | **ZIP** | |
| **ID OR POLICY #** | **GROUP / CODE** | | **EFFECTIVE DATE** | |

**SECONDARY INSURANCE INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SUBSCRIBER’S FIRST NAME LAST NAME** | | **RELATIONSHIP TO PATIENT** | | |
| **SECONDARY INSURANCE NAME**  SPOUSE OR INDIVIDUAL POLICY | | **ID OR POLICY #** | | **GROUP OR CODE #** |
| **ADDRESS** | | | | |
| **CITY** | **STATE** | | **ZIP** | |

**PATIENT AUTHORIZATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize SAH Consulting, Inc. to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, Blue Shield of Maryland, Medicare, and / or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company, be made directly to the above- (Name of other insurance company)

named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).

I certify that the information I have reported with regarded to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished me by that physician / supplier. I authorize any holder of medical information about me to release to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ any information needed to determine these benefits payable for related services. (Name of Medigap Carrier)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE SIGNATURE OF SUBSCRIBER OR BENEFICIARY

Sleep Disorders Screening Tool

Health Risk Assessment - Adult

SLEEP HISTORY

Height: \_\_\_\_ft. \_\_\_\_in. Weight: \_\_\_\_\_lbs. Weight gain / loss in the past 2 years: \_\_\_\_\_\_\_\_lbs.

Blood Pressure\_\_\_\_\_\_\_\_\_

Main Sleep Complaint/Reason for night-time awakenings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did this problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ years old

How does this affect your life and daily activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any previous evaluations, examinations or treatment for this sleep problem or any other problem with your sleep? Yes \_\_\_\_\_ No \_\_\_\_\_\_ If yes, briefly describe the evaluation, treatment and results, including medication.

If employed, what are your usual working hours? Start time \_\_\_\_\_\_\_\_\_\_ Stop time \_\_\_\_\_\_\_\_\_\_

What time do you usually go to bed and get up on weekdays (or work days)? \_\_\_\_\_\_ to bed \_\_\_\_\_\_ get up

What time do you usually go to bed and get up on weekends (or days off)? \_\_\_\_\_\_\_ to bed \_\_\_\_\_\_ get up

Section 1 Insomnia

Yes No

Do you have trouble falling asleep?

Are you bothered by thoughts that keep you from sleeping?

Are you frightened to go to sleep?

Do you feel depressed or sad?

Does it take you more than a half hour to fall asleep?

Do you awaken much earlier in the morning and are unable to fall

back to sleep?

Section 2 Sleep Apnea

Yes No

Do you often feel that you get too little sleep at night?

Are you bothered by sleepy periods during the day?

Do you remember dreaming?

Do you snore, or has someone told you that you snore?

Does the snoring disturb your bed partner or someone else in the house?

Are you bothered by nightmares?

Are you bothered by breathing problems at night?

Do you have unusual behavior during sleep?

Do you usually feel tired or sleepy during the day?

Do you have high blood pressure?

Have you been gaining weight?

Have you been undergoing changes in your personality?

Do you sweat during the night?

Do you feel you have lost interest in sex?

Do you waken gasping for breath in the middle of the night?

Do you have headaches in the morning?

When you have a cold do you find falling asleep more difficult?

Have you ever felt your heart pounding or beating irregularly during

the night?

Have you been told that your performance on the job is not up to

par?

Section 3 Narcolepsy

Yes No

Do you have difficulty concentrating at school or at work?

Have you fallen asleep at the wheel of a car?

Do you fall asleep during the day?

Have you ever fallen asleep while laughing or crying?

Do your knees get weak if you laugh or get angry?

Have you fallen asleep during physical exertion?

During the day, do you feel dazed as if in a fog?

If you become angry, does your body feel limp?

While falling asleep or awakening, have you experienced vivid

dreams?

Soon after falling asleep, have you had nightmares?

Do you often feel that you must fill your day with activity?

No matter how hard you try to stay awake, do you still fall asleep?

Section 4 GERD

Yes No

Do you gasp for breath during the night?

Do you awaken in the night coughing?

Are you hoarse in the morning?

Do you awaken with heartburn?

Do you have a chronic cough?

Are you taking antacids routinely on a weekly basis?

Do you have frequent sore throats?

Section 5 Restless Legs/PLMS

Yes No

Do you have pain that interferes with your sleep?

Do you awaken with muscle aches?

Do you have muscle tension in your legs, even outside of exercise?

Do you kick in bed at night?

Even though you sleep at night, do you awaken feeling tired?

Have you experienced a sensation of “crawling” or aching in your

legs?

At night, do you feel the need to move your legs?

**EPWORTH Sleepiness Scale**

How likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently try to estimate the effect it might have on your level of drowsiness. 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

(in a meeting or watching a movie) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 lunch

without alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In a car, while stopped for a few

minutes in the traffic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been told or do you have any of the following?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Problem | Yes | Time/Wk. | Age of onset | Last occurred |
| a. Talk while asleep |  |  |  |  |
| b. Walk while asleep |  |  |  |  |
| c. Grit teeth while asleep |  |  |  |  |
| d. Wake up screaming or afraid for no reason |  |  |  |  |
| e. Stop breathing in your sleep |  |  |  |  |
| f. Awaken with heartburn or sour taste |  |  |  |  |
| g. other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |

Does anyone in your family have any sleep problems? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

If yes, briefly describe and give their relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

Please list any medical problems, past or present.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | Type of Problem | Dates | Physician, Clinic or Hospital |
| Thyroid |  |  |  |  |
| Last blood test for thyroid |  |  |  |  |
| Eyes,ears,nose,mouth, throat |  |  |  |  |
| Heart, circulation (including blood pressure) |  |  |  |  |
| Head, nervous |  |  |  |  |
| Breathing (lungs) |  |  |  |  |
| Stomach, digestive |  |  |  |  |
| Urine, kidney |  |  |  |  |
| Sexual |  |  |  |  |
| Bones, joints, arms, joints |  |  |  |  |
| Diabetes, glands |  |  |  |  |
| Weight problems |  |  |  |  |
| Mental health |  |  |  |  |
| Other |  |  |  |  |

Have you had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Surgery | Yes | No | If yes, when? |
| Tonsillectomy |  |  |  |
| Adenoidectomy |  |  |  |
| Nasal or sinus surgery |  |  |  |
| Vocal cord surgery |  |  |  |
| Other surgery |  |  |  |

**MEDICATIONS**

* Do you use any prescription or over the counter medications regularly or occasionally? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list by name below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| List all medications (OTC, minerals, herbals, supplements, weight loss aids). | | | | | |
| Medication Name | Dose | How Often | How Long | Reason | Prescribing Doctor |
|  |  |  |  |  |  |
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For each of the beverages listed, write the average number you drink per day:

Regular coffee \_\_\_\_\_\_\_ cups/day decaffeinated coffee \_\_\_\_\_\_\_cups/day

Tea \_\_\_\_\_\_\_ cups/day caffeinated soft drinks \_\_\_\_\_\_\_cups/day

On the average, how many alcoholic beverages do you drink a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On the average, how much tobacco do you smoke? (Please fill in number per day).

Cigarettes \_\_\_\_\_\_\_ Cigars \_\_\_\_\_\_\_ Pipe \_\_\_\_\_\_\_\_ Chewing Tobacco\_\_\_\_\_\_\_\_

Do you get regular exercise? Yes\_\_\_\_\_ No \_\_\_\_\_

What kind \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often\_\_\_\_\_\_\_\_\_\_ Time of day \_\_\_\_\_\_\_\_

**Frequently asked questions about Sleep Testing (Polysomnography)**

***Most people are not familiar with sleep laboratory procedures and equipment. In the following, we will answer some of the more frequently asked questions about sleep disorders testing. After reading this material, if you have further questions about for your sleep study, please call us.***

1. **What is a polysomnogram?** A polysomnogram is a continuous recording of selected body functions during sleep. The test also records brain waves, eye movements, and muscle tone, which together determine the sleep stages. Heart rate, heart rhythm, sleep movements, and snoring sounds are also monitored. For possible sleep apnea, we record breathing and oxygen level. Additional polysomnographic measurements can be made in people with other suspected disorders.

2. **What sensors are applied during the recording?** Most of the sensors are tiny gold plated disks that are applied to the scalp and skin. Blood oxygen is monitored using an adhesive sensor that is applied to your finger throughout sleep. Respiration is monitored by using a very thin plastic sensor, which is placed between the nose and upper lip. Breathing effort is recorded using belts placed around the chest and abdomen.

3. **Will the recording be painful?** No. If you have sensitive skin, you may notice mild skin irritation from electrode paste or adhesive. We use no needles during this procedure and no blood tests are taken.

4. **Who will be present in the laboratory while I am sleeping?** A trained sleep laboratory technologist will monitor your sleep from an adjacent control area, while you sleep in a private room. The technologist has the responsibility to make your laboratory stay comfortable and safe while obtaining a high quality sleep recording.

5. **Will the recording procedure disrupt my sleep?** We will ask you to sleep some of the time on your back, whereas you may sleep in different positions at home. Also, most people find the sensors to be somewhat bothersome. *We know that your sleep in the laboratory will not be exactly the same as it is at home.* When we score and interpret your Polysomnographic recording, we will take into account any disruptive effects of sleeping in the laboratory. If you need to go to the bathroom during the night don’t worry, it won’t affect the sleep study. However, please let the technician know ahead of time if you have unusual patterns or frequency. The technicians will direct you as to how this works.

6. **Will I be given a sleeping pill?** No. We do not administer any medications for you. If you have very significant insomnia at home, your doctor may order a medication to improve your sleep in the laboratory. Since these medications may affect other aspects of the test, such as your sleep stages and your breathing, your doctor has to weigh those concerns against the possibility that you may not sleep as long without the medication. **PLEASE REVIEW ANY CHANGES IN MEDICATION WITH YOUR PHYSICIAN PRIOR TO TAKING ANY ACTION.** If you have any questions about medication, please contact your referring doctor.

7. **What should I do on the day of the test?**

* + Since the sensors are placed on the skin and scalp, we ask that all patients shower and shampoo their hair before arriving at the lab. Do not apply oil, hair spray, or heavy conditioners to your hair. Also, please do not apply any oils and lotions to your skin.
  + If you are scheduled for an overnight sleep study, we ask that you remain awake all day on the day of the test; please do not nap on the test day.
  + Please eat supper before reporting to the lab.
* 8. **Why is your questionnaire so long?** Our sleep technologists and physicians review your completed questionnaires. When our doctors interpret your test results in light of your complaints, usually we can better address your doctor’s concerns and your problems. **Similarly, please bring a report of any other sleep tests you may have already had.**
* 9. **What happens to my sleep recording after the test is done?** A qualified sleep technologist will score your test data, and a designated sleep center physician with expertise in clinical sleep physiology will interpret the results. The results will be forwarded to your physician, usually within two to three days after your study is completed.
* 10. **Can I shower at the sleep center before I leave?** Our recommendation is to plan to shower in a familiar setting at home, if at all possible. Our concern is that some patients, who are not familiar with our lab’s surroundings, could potentially slip and fall in our shower. It is in our patients’ best interest to plan to shower at home, if at all feasible, after their sleep study to remove the electrode paste from their hair.
* However, we do understand that there may be special, individual circumstances that may necessitate the use of our available, on-site showering facilities. In these special instances, we will provide towels and washcloths to our patients for their convenience.
* 11. **Will my insurance pay for my sleep testing** The Sleep Center tests are covered by most major health insurance carriers. You are only responsible for your deductible and insurance designated co-pay for a specialist. If you have any questions about billing or insurance coverage, please call your referring physician’s office or your insurance carrier directly. Please resolve any billing questions before your test date.
* Our goal is to make your sleep laboratory experience as comfortable and productive as possible. If we can assist you in any way, please do not hesitate to ask.
* **If you are excessively sleepy, have a relative or friend drive you to and from the laboratory.**
* **If this is not possible, use a taxi or other public transportation. Your safety is our priority.**

**Use this checklist to assemble the items you will need to bring to the Sleep Center**

* We provide all bedding including sheets, blankets, and **thin pillows (Bring your own pillows if you want)**
* Modest pajamas, or shorts/sweats and a t-shirt, or a lightweight cotton nightgown, or other comfortable, modest, sleepwear. (Please take into consideration that there will be other patients here and the bathrooms are located in the hallway, outside of your room)
* If you would like, you can bring a favorite pillow or blanket. (Even teddy bears are allowed!)
* Toiletries: comb, hairbrush, shampoo, toothbrush, toothpaste, and shaving materials.
* Clothes for the next day.
* **ANY NEEDED MEDICATIONS**. Lab personnel cannot supply or administer medications.

**If your doctor has recommended a sleeping aid for your appointment-**

**PLEASE DO NOT TAKE THIS BEFORE YOUR APPOINTMENT ARRIVAL.**

**PLEASE BRING THE PRESCRIPTION WITH YOU AND YOUR SLEEP TECHNOLOGIST WILL GIVE YOU FURTHER INSTRUCTIONS AND ANSWER ANY QUESTIONS THAT YOU MIGHT HAVE.**

* A list of all medications you have taken during the two weeks prior to the test. On the day of your test, do not alter your usual pattern of caffeine, medicine, or alcohol intake unless you have been advised to do so by your physician. However **we recommend limiting caffeine and alcohol after 4:00 p.m. on the day of your study, as both are stimulants and may affect your sleep efficiency.**
* **Directions to the Lab are located in this packet. Please bring Google or Yahoo map directions with you if needed.**
* **You may bring a book, magazine, or any other reading or work-related material, though there is no internet access available.**
* Sleep history questionnaire that we send to most people before testing.
* Insurance information sheet that we send to most people before testing.
* Insurance card
* Photo Identification, such as a driver’s license
* Physician Order Form or Prescription Form for your sleep study if applicable **(\*\*These are not the same as referrals)**