Mercy Sleep Center
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Oklahoma City, OK 73134
405.936.5208
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How to Prepare for your Home Sleep Study

1. **Do not** take a nap on the day of your study.
2. **Do not** drink anything with caffeine in it after 2 p.m. on the day of your study (this includes coffee, tea, soft drinks, ETC.)
3. **Do not** drink any alcohol on the day of your sleep study.
4. **Do** take your medications as prescribed by your doctor, unless otherwise directed by your doctor.
5. **Do** call Mercy Sleep Center 405.936.5208 if you have any questions
6. **Do** return the home sleep testing equipment to Mercy Sleep Center by 10 a.m. the following day.
7. Please notify us of any cancellations within 48 hours of your scheduled appointment.

***Please do not** arrive early for this appointment as the doors will remain locked until 7 p.m.*

Introduction to Obstructive Sleep Apnea and Nasal CPAP Therapy

This information is presented to help you better understand your sleep disorder and the treatment. We will answer some of the more common questions about sleep apnea and Nasal CPAP.

What is Sleep Apnea?
Sleep apnea refers to a condition that occurs while you are sleeping when no air is able to get into your lungs.

What happens to a person who has sleep apnea?
When movement of air in and out of your lungs is disturbed, less oxygen is delivered to the blood. This causes you to wake up many times during the night. As a result, you don't get enough of the right kind of sleep.

How do you know you have this?
Your doctor will order (or had ordered) a test that evaluates your sleep patterns. Small painless electrodes are applied to monitor brainwave activity (to help determine sleep stages). EKG (heart rate), EMG (muscle activity), and EOG (eye movements). A thermocouple placed under your nose is used to monitor airflow, electrode belts are used to monitor respiratory chest effort and abdominal effort, and a flexible probe is placed on your finger to monitor your blood oxygen saturation. In addition, a snore microphone is used to determine the amount of the night you spend snoring. The technician will monitor these channels of information on a computerized polysomnographic machine.

How will Nasal CPAP Help?
The nasal CPAP system works to prevent the structures in the throat from blocking air movement in and out of your lungs. To do this a small amount of pressure is applied through your nose. The pressure works to keep the airway open, which allows air to move form your nose to the top of your windpipe. It splints the airway open with air.

As long as you are able to move air in and out of your lungs, you will have enough oxygen. Your sleep will no longer be disturbed by too little oxygen. Thousands of people worldwide are already using this system

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How do you use Nasal CPAP treatment?

You will need to use Nasal CPAP only during the time you normally sleep. You will receive thorough instructions at the Sleep Diagnostic Laboratory and from your home care dealer before using it at home.

You and your family will learn how to connect tubing and valves and how to operate the blower unit. With the proper training, the equipment is easy to use.

Is this therapy dangerous?

The sleep study allows your doctor to know how much pressure you will need to be sure you get just enough to treat apnea. The equipment you are using at home can't be accidentally adjusted to levels other than what your doctor ordered. Pressure levels prescribed are very low. In fact, you build up more pressure in your lungs when you cough or sneeze.

If you lose your electrical power or should you displace the mask during sleep, you will continue to breathe through your mouth as you usually do.

How long will I need Nasal CPAP?

This will depend upon a number of factors. To be most effective, you must follow the treatment plan worked out for you by your doctor and consult your doctor if you have any questions or problems.

If you have Obstructive Sleep Apnea Syndrome, your doctor may prescribe weight loss as well as Nasal CPAP therapy.

What will Nasal CPAP do for me?

Nasal CPAP will help you breath better during your sleep. This means you won't interrupt your sleep during the night and you will be able to get enough of the right kind of sleep. You should notice some of the following effects:

1. Less daytime sleepiness.
2. Feeling more alert.
3. Improved memory.
4. More motivation.
5. Better work performance.
6. An overall improved outlook on life.

We are happy to have the opportunity to help you. If you have any questions before or after the sleep study, please call us and leave a message at the phone number below. One of the technicians will call you back as soon as possible.

Understanding your health just got easier

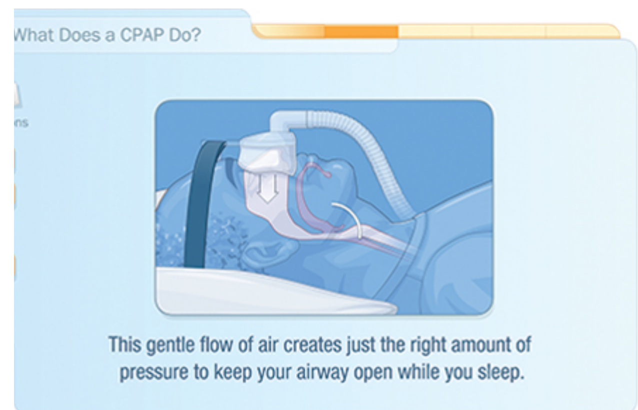
Ask Your Doctor About Emmi

What is Emmi?

Emmi® is a series of free, animated online programs that walk you through important information about what you need to know before your sleep study. You can watch Emmi programs as many times as you like and you can share them with your family and friends.

Learn More About Your Health

Doctors try to explain everything about your health but sometimes it gets confusing. Emmi programs help to answer your questions and make you feel more at ease about your experience in the sleep lab. You are the most important member of your health care team, so you should have all the information you need.



© 2014 Emmi Solutions, LLC. CPAP (Continuous Positive Airway Pressure) for Sleep Apnea program

© 2014 Emmi Solutions, LLC. Sleep Study program

Ready to learn more?

Look out for your Emmi instructions via MyMercy, your email and/or a phone call from us!

Need Help?
Email: support@emmisolutions.com **Phone:**866.294.3664

Epworth Sleepiness Scale

Name: ______________________________ Date: ______________

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations. This refers to your usual life in recent times, even if you have not done some of these 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**
1. Sitting and reading	________
2. Watching Television	________
3. Sitting inactive in a public place (i.e. theater or meeting)	________
4. As a Passenger in a car for 1 hour without a break.	________
5. Lying down to rest in the afternoon when circumstances permit	________
6. Sitting and talking to someone	________
7. Sitting quietly after lunch without alcohol	________
8. In a car, while stopped for a few minutes	________
Total	________

Sleep Questionnaire

Name: ______________________________ Age: ________ Sex: ________

Referring Physician: ______________________________ HT: ________ WT: ________

Please give the completed questionnaire to the technician at the time of your sleep study.

My primary sleep complaint is: ______________________________

How long have you had this problem? ______________________________

Have you ever seen a physician for this problem? ______________________________

Have you ever had a sleep study? ______________________________

(If yes, when and where) ______________________________

Do you use CPAP at Home? What Pressure? ______________________________

If currently using CPAP what is the need for this study? ______________________________

Do you use Oxygen at Home? ☐ No ☐ Yes ☐ 24HR/DAY ☐ Night Only

Medication	Dosage	Reason for taking

Pertinent Medical History *(Check those that apply)*

- ☐ High Blood Pressure
- ☐ Kidney Failure
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Stroke
- ☐ Premature Birth
- ☐ Cardiovascular Disease
- ☐ Thyroid Disease
- ☐ Heart Attack
- ☐ Memory Loss
- ☐ Seizures
- ☐ Parkinson's Disease
- ☐ Mood Disorder
- ☐ Fibromyalgia
- ☐ History of Sports Related Concussion
- ☐ Head Injury
- ☐ Neuromuscular Disease
- ☐ Nighttime Heartburn
- ☐ Allergies
- ☐ CHF (Congestive Heart Failure)
- ☐ Smoker: Cigarettes, Vape, Cigars *(Please Circle)*
- ☐ History of Motor Vehicle Accident

Chronic Lung Conditions *(Please check only those that have been diagnosed by your physician)*

- ☐ Pulmonary Hypertension
- ☐ Lung Cancer
- ☐ Emphysema
- ☐ Cystic Fibrosis
- ☐ Chronic Bronchitis
- ☐ ALS
- ☐ Pulmonary Fibrosis
- ☐ COPD
- ☐ Occupational Lung Disease
- ☐ Bronchiectasis
- ☐ Myasthenia Gravis

Surgeries *(check those that apply)*

- ☐ Tonsils
- ☐ Adenoids
- ☐ UPPP
- ☐ Deviated Septum
- ☐ Uvula Removal
- ☐ Nasal Polyp
- ☐ Tracheotomy
- ☐ Jaw Reconstruction
- ☐ Nasal Surgery

Sleep Pattern

What is your normal bedtime? ____________________

What time do you normally awaken? ____________________

How long does it usually take you to fall asleep? ____________________

Do you awaken often during the night? ____________________

(If yes, Why?) ____________________

Do you nap during the day? ____________________

(If yes, do you feel refreshed upon awakening?) ____________________

Do you work different shifts? ____________________

(If yes, what shift(s) do you work?) ____________________

Place a check mark in front of any statement that applies to your sleep patterns, if the statement does not apply leave it blank.

Excessive Daytime Sleepiness

☐ I fall asleep at work.

☐ I get sleepy while driving.

☐ I have fallen asleep while driving.

☐ I fall asleep at meetings.

☐ I don't feel refreshed when I awaken.

Restless Leg Syndrome or Nocturnal Myoclonus

These questions help to determine if you have Restless Leg Syndrome. *(Please check the appropriate answer.)*

1. Do you have the urge to move legs while awake, usually accompanied by an uncomfortable feeling in the legs.

   ☐ Yes ☐ No

2. Does rest or inactivity worsen the symptoms?

   ☐ Yes ☐ No

3. Do your symptoms get better with activity?

   ☐ Yes ☐ No

4. Do your symptoms get worse in the evening or night?

   ☐ Yes ☐ No

5. How often do you experience the symptoms above?

   ☐ Rarely

   ☐ A few times a month

   ☐ More than 2 times a week

   ☐ Almost Everyday

Insomnia

☐ I have trouble getting to sleep at night.

☐ I have trouble staying asleep at night.

☐ I awaken in the morning long before I want to.

☐ I worry I will be unable to sleep.

☐ I awaken with feelings of anxiety or fear.

Sleep Behavior

☐ I have been told I walk in my sleep.

☐ I have been told I talk in my sleep.

☐ As an adult, I have wet the bed.

☐ When I laugh or get angry, I feel like I'm going limp.

☐ I have fallen asleep while laughing or crying.

☐ I have vivid dream-like scenes upon falling asleep.

☐ I feel like I walk around in a daze.

☐ Sometimes I can't tell dreams from reality.

Sleep Apnea

☐ I have been told that I snore

☐ Others can't sleep in the same room because I snore.

☐ I have been told I stop breathing while asleep.

☐ I awaken with headaches.

☐ I'm overweight or am gaining weight.

☐ I perspire at night.

☐ I have been told I'm a restless sleeper.

☐ I have awakened during the night choking.