**WINCHESTER NEUROLOGICAL CONSULTANTS, INC.**

**SLEEP CENTER**

# PATIENT RIGHTS AND RESPONSIBILITIES

WNC, Inc., Sleep Center and Medical Staff have adopted the following list of patient rights and responsibilities. This list shall include, but is not limited to, the following:

 **Patient Rights:**

* You have the right to considerate and respectful treatment
* You have the right to receive treatment without discrimination as to race, religion, sex, national origin, or source of payment.
* You have the right to privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third party contact. You may approve or not approve the release of medical information.
* You have the right to ask questions and to an understandable explanation of the diagnostic or treatment component.
* You have the right to be fully informed of what services are available at the sleep lab, as well as of the fees for all services.
* You have the right to participate in decisions regarding your treatment and to be fully informed of the benefits and risks associated with any treatment component.
* You have the right to refuse any diagnostic procedures and treatment and, to the extent permitted by law, to be informed of the risks associated with refusing to be treated.
* You have the right to express complaints and concerns at any time.
* You have the right to change your medical provider at any time.
* You have the right to express those spiritual beliefs or cultural practices that do not harm others or interfere with medical procedures.
* You have the right to seek assistance (interpreter, wheelchair, etc.) during your visit. (Please ask attending technician.)

**Patient Responsibilities:**

* You have the responsibility to keep your appointments at WNC, Inc. Sleep Center, to be on time, and when unable to do so, to provide 24 hour notice to reschedule or cancel.
* You have the responsibility to be considerate of other patients and staff.
* You have the responsibility to respect the property of others and WNC, Inc. Sleep Center.
* You have the responsibility to let your medical care provider know when you do not understand what is being told to you with regards to your treatment or illness.
* You have the responsibility to report any changes in your address, telephone number and financial status.
* You have the responsibility to obtain previous medical records when requested.
* You have the responsibility to provide accurate information on the medical history questionnaire.
* You have the responsibility to do what you and your healthcare provider have agreed upon with regards to treatment. You must understand that if you do not do so, then you will be responsible for the outcome.
* You have the responsibility to be honest with the sleep lab personnel.

**What Happens During a Sleep Evaluation?**

You will spend one night sleeping in a private room with a comfortable bed and personal temperature control. Cable television and shower facilities are available (towels are provided upon request). Some people may need to stay two non-consecutive nights, but typically, you will arrive in the evening and leave the following morning; it is usually not necessary to miss a day of work or school.

A sleep study at Winchester Neurological Consultants is a comprehensive, safe and painless procedure that measures brain activity, eye movement, heart rate, pulse, blood oxygen levels, snoring, breathing and airflow, and body movements while you sleep. Highly skilled and trained specialists monitor your data throughout the night. The data is then reviewed by a physician and the results are provided to you and your physician in a timely manner.

**What is a polysomnogram?**

A polysomnogram is a procedure which measures bodily functions during sleep. Each study will vary depending on the individual case. Some of the measurements taken may include:

* Brain Waves (Electrodes placed on the scalp)
* Heart Beats (Electrodes placed on the chest)
* Eye Movements (Electrodes placed above and below the eyes)
* Muscle Tension (Electrodes placed on the chin)
* Leg Movements (Electrodes placed on the lower leg)
* Airflow Breathing (Sensor placed in your nostrils)
* Chest and Abdominal Breathing (Sensors placed around the chest and abdomen outside of your pajamas)
* Blood Oxygen Levels (a small sensor attached/taped to your finger)

**Why record all these things?**

During sleep, the body functions are different than while awake. Disrupted sleep can disturb daytime activities and sometimes medical problems during sleep involve a risk to your health.

**How can I sleep with all these things on me?**

Surprisingly, most people sleep reasonably well. We are only looking to obtain a sample of your sleep. The body sensors are applied so that you can turn and move during sleep. None of the electrodes break the skin. The entire procedure is painless. Our staff will try to make your sleeping environment as comfortable as possible.

**Will the sensor devices hurt?**

No. Sometimes, in rubbing the skin or putting on the electrodes, there are mild and/or temporary skin irritations. You may also feel a sensation of warmth where the oxygen-measuring device contacts the skin of your finger. However, these do not generally cause any significant discomfort.

**Will I be given a drug in the sleep lab to help me sleep?**

IMPORTANT: PLEASE DO NOT STOP ANY OF YOUR MEDICATIONS WITHOUT FIRST CONSULTING YOUR PERSONAL PHYSICIAN. Your doctor may instruct you to stop taking certain medications before coming for the test. It is also important not to consume any alcohol or caffeinated beverages on the day of the testing.

Technologists do not have sleeping aids available.

**MSLT Test Instructions**

You will leave our office at 5:30 am once the sleep study is over and return to the office between 7:15-7:30 am if an MSLT has been scheduled.  You will have to bring your own supply of medication and food.  A refrigerator and microwave are available.  You cannot drink caffeine prior or during the MSLT.  The MSLT study usually lasts till 4:30 pm.

**What YOU need to do for a successful Sleep Study**

**Sleep Study Preparation Checklist:**

**(Use this as your checklist before arriving for your sleep study)**

**Avoid -**

* Avoid napping.
* Avoid alcohol, marijuana and any illicit drug use at least 12 hours prior to testing. Winchester Neurological Consultants has a Zero Tolerance Policy.
* Avoid caffeine after 12 pm (noon).
* Avoid using sprays, oils, gels or lotions in your hair and on your skin.
* Avoid makeup on the face.

**Do -**

* Do shower and wash your hair with shampoo only.
* Do remove hairpieces and/or hair weaves to allow for electrode placement.
* Do have one fingernail free of nail polish and/or acrylic nails.
* Do shave before you arrive for you study, except if you have a full beard or mustache.
* Do arrive on time at 7:45 p.m. with the appropriate paperwork, if available.
* Do have someone pick you up in the morning if you are unable to drive.

You will be discharged at approximately 5:30 a.m.

**Bring -**

* Bring health insurance card.
* Bring all medications including antacids and ibuprofen, etc.
* Bring sleep aid if prescribed. Take this only when instructed to do so by the sleep technologist.
* Bring your PAP mask and settings if you are a current PAP user.
* Bring your glucometer, insulin, and a snack if you are diabetic.
* Bring a book or magazine if desired. Televisions are available in each room.
* Bring a pillow if you choose.
* Bring pajamas or t-shirt and gym shorts to sleep in.
* Bring toiletries for before bed and in the morning (toothbrush, toothpaste, shampoo, face soap).

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## SLEEP DISORDER QUESTIONNAIRE

# **Name:**

1. Are you bothered by sleepiness under other circumstances? Yes [ ]  No [ ]
If yes, describe:
2. Have you been in a car accident due to falling asleep at the wheel? Yes [ ]  No [ ]
3. Have you had a near miss due to falling asleep at the wheel? Yes [ ]  No [ ]
If yes, describe:
4. Have you had other types of accidents because of sleepiness: Yes [ ]  No [ ]
If yes, describe:
5. If employed, what are your working hours? Start: am/pm Stop: am/pm
6. How long have you been on this work schedule?
7. How many naps do you take in a usual week?
8. Are the naps refreshing: Yes [ ]  No [ ]

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\*Past sleep studies or surgery related to sleep disorders:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Initial Study: |  | Location: |  | Physician: |  |
| CPAP/BIPAP study: |  | Location: |  | Physician: |  |
| Post ENT Study: |  | Location: |  | Physician: |  |
| If you use the following equipment , please complete the blanks: |
| CPAP Pressure: |  Cm/H2O  | BIPAP Pressure: Cm/H2O | Oxygen: |  LPMH |

Has anyone in your family been diagnosed with a sleep problem? No [ ]  Yes [ ]  Relationship:\_\_\_\_\_\_\_

What is the average number of drinks you have per day of:

 Caffeinated beverages:\_\_\_\_\_\_

 Alcoholic beverages:\_\_\_\_\_\_

Do you smoke? Yes [ ]  No [ ]  For how long? Number per day?

Excluding pregnancy, what has the range of your weight been over the past five (5) years?

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SLEEP DISORDER QUESTIONNAIRE

 Sleep History

**Check any of the following symptoms that you currently have when sleeping or trying to sleep.**

|  |  |  |
| --- | --- | --- |
| [ ]  Toss & turn | [ ]  Fall out of bed | [ ]  Bed Wetting |
| [ ]  Heartburn | [ ]  Sour Belches | [ ]  Pain |
| [ ]  Regurgitation | [ ]  Night Sweats | [ ]  Teeth Grinding |
| [ ]  Cold feet | [ ]  Sleep Walking | [ ]  Sleep talking |
| [ ]  Nightmares | [ ]  Irresistible urge to move  legs | [ ]  Legs jerking |

**Check any of the following that you experience during sleep.**

|  |  |  |
| --- | --- | --- |
| [ ]  Choking | [ ]  Making Whistling noises | [ ]  Gasping for air |
| [ ]  Loud Snoring | [ ]  Struggling to breathe | [ ]  Stop breathing |
| [ ]  Sleeping with mouth open | [ ]  Waking yourself with  snoring | [ ]  Snorting |
| [ ]  Waking up with dry mouth |  |  |

1. Do you snore in all positions? Yes [ ]  No [ ]  If not, when?
2. What time do you usually go to bed? a.m. [ ]  p.m. [ ]
3. How many times do you awaken during the night and why?
4. Do you have trouble returning to sleep? Yes [ ]  No [ ]
5. What time do you usually wake up in the morning? a.m. [ ]  p.m. [ ]
6. Do you usually sleep longer when you do not have to get up? Yes [ ]  No [ ]  How long?
7. How many hours of actual sleep do you think you get each night on average?
8. Upon wakening in the morning, do you feel: Completely rested [ ]  Partially rested [ ]  Not rested at all [ ]
9. Do you frequently have a headache during the night or in the morning? Yes [ ]  No [ ]
10. Do you take anything to help you sleep? Yes [ ]  No [ ]  If yes, what?
11. As you fall asleep or wake up, do you have vivid lifelike visions (people in the room, etc.) Yes [ ]  No [ ]
12. When you are angry or excited, do you feel sudden weakness or have any part of your body go limp (head drops, knees buckle, etc.) Yes [ ]  No [ ]
13. As you are trying to go to sleep or wake up, do you ever have an inability to move? Yes [ ]  No [ ]
14. Have you ever driven or traveled somewhere and did not remember how to get there? Yes [ ]  No [ ]