BOZEMAN HEALTH
DEACONESS HOSPITAL

DIAGNOSTIC SLEEP CENTER

ATTENTION:
We request that all non-Medicare patients contact their insurance company to obtain benefits before their sleep study appointment.

Test Codes:
Polysomnogram: 95810
Polysomnogram w/Cpap: 95811
Multiple Sleep Latency Test
(day time study): 95805
Unattended Sleep Apnea Test: 95806

Diagnostic Sleep Center
905 Highland Boulevard | Bozeman, MT 59715 | Tel: 406-414-5058 | Fax: 406-414-5054
BozemanHealth.org

BOZEMAN HEALTH
DEACONESS HOSPITAL

PATIENT INSTRUCTIONS PACKET

Your Appointment Details

Date: _____

Time: _____

Dear patient,

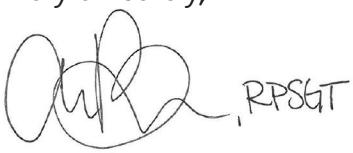
Thank you for choosing Bozeman Health Diagnostic Sleep Disorders Center for your evaluation. Enclosed, please find important information and instructions regarding your upcoming test. Please read this packet thoroughly BEFORE your appointment date. Please fill out the questionnaire provided and bring it with you to your appointment.

Special Assistance Requirements
Please understand that we are not staffed to render anything other than basic assistance. If you require assistance showering, we ask that you wait to do so when you return home. If you require any other special assistance, please contact us in advance.

Campus Policies
Bozeman Health Deaconess Hospital is a smoke-free, weapons-free campus.

If you have any questions, or need to address any of the above, please call us at 406-414-5058. Thank you for the opportunity to serve you.

Very sincerely,



Amanda Broyles, RPSGT
Sleep Center Supervisor
Bozeman Health Diagnostic Sleep Center

Diagnostic Sleep Center
905 Highland Boulevard | Bozeman, MT 59715 | Tel: 406-414-5058 | Fax: 406-414-5054
BozemanHealth.org

PATIENT INSTRUCTIONS

Polysomnography evaluations are quite different from any other medical testing that you may have experienced in the past. This information is meant to inform you of what you may expect as a patient at our center.

Study Confirmation

It is necessary for us to be able to confirm your study the day before your study date. If you plan on being out of town or in a place where we cannot reach you, it is your responsibility to call us to confirm your attendance at the appointed date and time.

Accommodations

Your study will be conducted in a private room, similar to a hotel room, with a Sleep Number™ bed, TV, Wi-Fi, and private bath. We do not supply toiletries, so plan on packing toothbrush, toothpaste, shampoo, hair dryer, etc. Feel free to bring other items to make yourself comfortable, such as robe and slippers, book, electronic device, favorite blanket, snacks, earplugs, etc.

Pillows

Feel free to bring your own pillow(s). We provide four hospital pillows, but many patients prefer their own.

Meals

Please eat dinner before you arrive. We will provide a meal voucher for breakfast that can be used at either the coffee shop or cafeteria (open at 7 a.m.). Juice is available in lab. Let us know how we can make your stay comfortable.

Showering

The paste used to secure electrodes to your scalp is water soluble and will come out with shampooing. However, it takes a little more time to remove it all. You are welcome to shower here, but please be advised that the center is not staffed to aide patients in bathing or dressing.

Getting the Results

Please allow 14 days for your physician to receive the results of your sleep study. Our lab staff are not able to diagnose sleep disorders or prescribe treatment for sleep disorders.

Diagnostic Sleep Center
905 Highland Boulevard | Bozeman, MT 59715 | Tel: 406-414-5058 | Fax: 406-414-5054
BozemanHealth.org

PROCEDURES YOU NEED TO FOLLOW:

Please read through this instruction packet in its entirety.

1. Please fill out the enclosed sleep questionnaire and bring it with you the night of your study.

2. Report to the Diagnostic Sleep Center at your scheduled time.

3. If you anticipate needing to reschedule/cancel, please give us a 48 hours notice so we can provide the time slot to another waiting patient.

4. If you are delayed because of a problem or emergency, please call 406-414-5058 so that the staff will be aware. If you are unable to reach anyone in our office, please leave a message.

5. Please shampoo your hair the day the day of the study, but use no conditioner or other hair products. This is necessary to ensure a good EEG reading.

6. Sleeping attire is mandatory. Please bring loose clothing such as pajamas, shorts or sweats, as we will need to run some electrodes under your clothing.

7. WOMEN: Please plan on removing acrylic nails and nail polish from at least one finger.

8. MEN: If you have a full beard, you do not need to shave, otherwise please be clean-shaven or plan on shaving when you arrive. This is necessary for the attachment of certain leads to your chin.

9. Do not take any non-routine naps during the day or evening you are scheduled.

10. Eat dinner and take your medications as usual. Bring any bedtime medications, including over-the-counter drugs, that you need as we are not able to dispense medications from our facility.

Your cooperation with the above guidelines is appreciated and necessary to ensure that we receive accurate results from your evaluation. Thank you.

Diagnostic Sleep Center
905 Highland Boulevard | Bozeman, MT 59715 | Tel: 406-414-5058 | Fax: 406-414-5054
BozemanHealth.org

ESSENTIAL INFORMATION

Insurance

While sleep disorders are recognized as medical problems, insurance policies and coverage vary considerably. The Diagnostic Sleep Center will work through the clinical documentation insurance pre-authorization process (when required) prior to scheduling. We do suggest that you contact your insurance provider prior to testing to check your benefits and out-of-pocket responsibilities.

Procedure Codes:

95810 – Polysomnography

95811 – Polysomnography with CPAP

95805 – Multiple Sleep Latency Test (daytime study)

Diagnosis Code:

G47.33 – Obstructive Sleep Apnea

Directions

1. **From Main Street** - turn north on Highland Boulevard, turn right onto Ellis Street just before you reach Bozeman Health Deaconess Hospital. Proceed to the stop sign and turn left onto Old Highland Boulevard. As you come around the backside of the hospital, take your second left and park in lot "F"(Fish) as close to Entrance 8 as possible (refer to map, enclosed).

   From Kagy - drive south on Highland Boulevard, turn left onto Old Highland Boulevard. When behind the hospital, turn right into the "F"(Fish) parking lot and park as close to the Entrance 8 as possible.
2. Enter the building through the glass doors and take the elevator to the second floor. The Diagnostic Sleep Center is directly to your right as you exit the elevator.
3. Pick up the phone at the front door to the office to alert the technicians of your arrival.

If you have any questions about our location, please call us at 406-414-5058.

Diagnostic Sleep Center
905 Highland Boulevard | Bozeman, MT 59715 | Tel: 406-414-5058 | Fax: 406-414-5054
BozemanHealth.org

BOZEMAN HEALTH
DEACONESS HOSPITAL

Campus Map

BREATHE RIGHT, SLEEP TIGHT

Dear Patient,

Having a sleep disorder can be a very challenging issue. We want to help you find success in overcoming your sleeping hang-ups in anyway we can.

Your sleep specialist may find that your sleep disorder is a symptom of irregular breathing. That is why we at Bozeman Health Home Oxygen have partnered with Sleep Medicine Clinic in finding the right solution for you. We will work with your physician and technicians in finding the specific sleeping equipment necessary to help you start breathing right, so you can start sleeping tight.

We work in conjunction with the Sleep Medicine Clinic loaner mask program, allowing you to try as many different options as needed—with no obligation to buy—until you find the perfect fit.

Please stop in on your way to or from your sleep appointment. We'd love to introduce ourselves and hopefully help you get some sleep.

Sincerely,

Merle Phipps, RRT, RPSGT
Manager

BOZEMAN HEALTH
DEACONESS HOSPITAL

Home Oxygen

406-414-5053 | 905 Highland Boulevard | Bozeman, MT 59715 | BozemanHealth.org

773- SDC-8(10-16-15) MR Form

BOZEMAN HEALTH DEACONESS HOSPITAL

Patient Label

Name: _____

DOB: _____

M#:_____

Quest

PATIENT QUESTIONNAIRE

PLEASE USE THE PRE-PAID ENVELOPE PROVIDED TO RETURN THE
FOLLOWING COMPLETED QUESTIONNAIRE PRIOR TO YOUR APPOINTMENT.

_____ _____ _____
NAME DOB HOME PHONE

_____ _____
ADDRESS WORK PHONE

_____ _____ _____
CITY STATE ZIP

_____
REFERRING PHYSICIAN

My main sleep complaint is:

- ❑ **I have trouble sleeping at night.**
- ❑ **I am sleepy all day.**
- ❑ **I have unwanted sleep behaviors when I am asleep.**

Please explain: _____

_____

_____

BOZEMAN HEALTH DEACONESS HOSPITAL

Patient Label

Name: _____

DOB: _____

M#:_____

Quest

SEARLE GLOBAL SLEEP ASSESSMENT QUESTIONNAIRE

Developed by Buysse DJ, Young T, Roth T, Simon RD Jr., Dement WC, Kushida CA, and Walsh JK

Instructions: Answer the questions below by writing on the line provided or circling the most correct answer. Please select only one answer for each question.

Name: _____ Employment Status: ❑ Day shift ❑ Night Shift ❑ Rotation shift ❑ Retired ❑ Unemployed ❑ Part-time ❑ Homemaker ❑ Disabled

Age: _____ Height: _____ Weight: _____ Gender: ❑ Male ❑ Female

Family Physician: _____ Referring Physician: _____

❑ Smoker How many packs per week? _____ How many years? _____

❑ Non-Smoker

Over the past month, have you had any major traumatic or stressful event(s) that you feel affected your sleep? If so, please describe: _____

Over the past month

1. How would you rate the quality of your sleep?
   Very good Fairly good Fairly poor Very poor

2. a.) What time did you go to bed on workdays? _____
   b.) What time did you get out of bed on workdays? _____

3. a.) What time did you go to bed on non-workdays? _____
   b.) What time did you get out of bed on non-workdays? _____

4. How many nights did you have trouble falling asleep or staying asleep?
   Zero 1-5 6-15 More than 15

5. Approximately how many minutes did it usually take you to fall asleep once you decided to sleep?
   0-5 minutes 5-30 minutes 31-60 minutes Over 60 minutes

6. Approximately how many times did you typically awaken each night?
   0-1 2-3 4-5 More than *5*

7. How often did you fall asleep or fight to stay awake during the daytime?
   0 times/week 1-2 times/week 3-4 times/week More than 4 times/week

8. How much did you worry about sleep or problems sleeping?
   Not at all A little bit Quite a bit All the time

9. Approximately how many hours of sleep did you actually get each night, not counting time awake?
   Less than 6 hours Between 6 hours and 8 hours Between 8 hours and 10 hours

10. Approximately how much time did you typically spend awake in bed each night?
    More than 10 hours Less than 30 minutes 31 -60 min 1-2 hours More than 2 hours

BOZEMAN HEALTH DEACONESS HOSPITAL

Patient Label

Name: _____

DOB: _____

M#:_____

Quest

11. How often did you feel fatigued, but not sleepy during the daytime?
0 times/week 1-2 times/week 3-4 times/week More than 4 times/week

12. How often did you snore (based on your own knowledge or what others have told you)?
Never Rarely Sometimes Often Nightly

13. How loudly did you snore (based on your own knowledge or what others have told you)?
None Softly Somewhat loudly Loudly Very loudly

14. How often did you hold, pause, or stop breathing in your sleep (based on your own knowledge or what others have told you)?
0 times/night 1-2 times/night 3-4 times/night More than 4 times/night

15. How often did you have restless or "crawling" feelings in your legs at night that went away if you moved your legs?
0 times/night 1 -2 times/night 3-4 times/night More than 4 times/night

16. How often did you have repeated leg jerks or leg twitches at night (based on your own knowledge or what others have told you)?
0 times/week 1-2 times/week 3-4 times/week More than 4 times/week

17. How often did you scream, walk, or punch in your sleep (based on your own knowledge or what others have told you)?
0 times/week 1 -2 times/week 3-4 times/week More than 4 times/week

18. How many caffeinated beverages (coffee, cola, etc.) did you typically consume per day?
None 1-7 /day 8-14 /day More than 14/day

19. How many drinks containing alcohol did you typically consume per day?
None 1-7 /day 8-14 /day More than 14/day

20. How many prescription or non-prescription medications (except vitamins, aspirin, or dietary supplements) did you take for any purpose on a daily basis?
0-1 2-3 4-5 More than 5

21. How many times did you take a prescription or non-prescription medication for sleep?
Zero 1-6 nights 7-15 nights More than 15 nights

22. In general, how would you rate your health?
Excellent Very good Good

23. Have health problems affected your ability to perform daily activities?
Not at all A little bit Quite a bit

24. How sad or anxious have you felt?
Not at all A little bit Quite a bit

25. How much have you enjoyed your usual activities?
Completely Quite a bit A little bit

26. How often did a poor night's sleep interfere with your activities the next day?
Never Rarely Sometimes Often Nightly

773- SDC-8(10-16-15) MR Form

BOZEMAN HEALTH DEACONESS HOSPITAL

Patient Label

Name: _____

DOB: _____

M#:_____

Quest

Epworth Sleepiness Scale©

In the past month or so, how likely are you to doze off or fall asleep in the following situations?

0 = never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
1. Sitting and reading	
2. Watching TV	
3. Sitting inactive in a public place (i.e. a theatre or meeting)	
4. As a passenger in a car for an 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 a lunch without alcohol	
8. In a car stopped for a few minutes in traffic	
	Total **/24**

Medication	For what?	Dosage	How often?	How long?

Summary:

Briefly describe the nature of your sleep/wake complaint, as well as anything else that interferes with your sleep or daytime wakefulness. Also, add any pertinent information that your physician should know about your sleep:

_____

_____

_____

_____

_____

BOZEMAN HEALTH DEACONESS HOSPITAL

Patient Label

Consent

Name: _____

DOB: _____

M#:_____

Sleep Disorders Center Consent for Treatment

Consent for treatment: The Sleep Disorders Center uses a variety of leads and monitoring devices in order to record your sleep. These include, but are not limited to:

1. EEG Electrodes—small electrodes placed on the scalp in order to monitor brain waves (the number of these leads may vary depending on the type of study we are running).
2. EOG Electrodes—small electrodes taped outside of the eyes used to monitor eye movements.
3. EMG Electrodes—small electrodes used to monitor muscle tension in different areas of the body, usually, the chin and front of both legs.
4. Nasal/Oral Airflow Pressure Sensors—devices used to monitor airflow or pressure through the nose and mouth.
5. Thoracic and Abdominal Effort Belts—flexible belts worn around the chest and abdomen that measure the rise and fall of the chest and abdomen.
6. EKG Electrodes—small electrodes used to record the heart rhythm; typically, we use two electrodes which are placed on front of the chest.

Additional devices, which are sometimes used, will be explained as needed include CPAP/BIPAP. These are devices that are often used to treat sleep apnea. A small mask is worn over the nose and is connected to a small machine that delivers air pressure to maintain patency in the airway.

Please initial the following:

_____ I understand that I will be billed separately for the Sleep Center physician's professional component as described in the Sleep Disorders Center packet.

_____ I hereby consent to the use of audio/video monitoring/recording during my stay in the Sleep Disorders Center. I understand that these recordings are used to aide in the diagnosis and treatment of sleep disorders and that they are to be kept by the Sleep Disorders Center for a period of time (up to ten years). Recordings will be destroyed at the end of the archival period.

_____ I consent to the release of information pertinent to my care from my referring physician to the Sleep Disorders Center.

I certify that I have read the above information and as the patient, or one who is duly authorized to act in a representative capacity of the patient, that the information has been fully explained, that I understand its contents, that it may not be modified and that I may withdraw my consent for services at any time.

_____ _____

Patient/Guarantor Signature Date

Reason patient is unable to sign:

_____ _____ _____

Date Witness