

Sleep Laboratory at Virginia Hospital Center

Lawrence M. Stein, MD, FACP, FCCP, FAASM
Medical Director

Ponnarit Loeu, RPSGT
Technical Director

Welcome to the Sleep Laboratory at Virginia Hospital Center where an overnight stay could pinpoint what is causing your sleep disruptions. Our board-certified physicians can simultaneously record brainwaves, muscle activity, heart rhythms, belly and chest wall effort, air flow to the nose and mouth, snoring patterns, blood oxygen levels and nerve impulses to the eye. These factors can help identify the onset of REM (rapid eye movement) dream states and possible impediments to sound sleep.

If you have been scheduled for sleep testing at Virginia Hospital Center, please read the following instructions:

Location: The Sleep Laboratory is located on the first floor of 1625 N. George Mason Drive, adjacent to Cardio Pulmonary.

Parking: Please park in the "Blue" Garage; take the garage elevators to the ground floor; proceed through the Registration area of the Emergency Department and ask for the bed control clerk.

Registration: Please arrive at Virginia Hospital Center by 8:45 P.M. Security will direct you to Patient Registration once you arrive in the Emergency Department. After registering please proceed to the Coffee Stand in the Main Lobby, a sleep lab technician will escort you to the Sleep Center at 9:00 pm.

Cancellations: If you are unable to keep your appointment, please call our patient care coordinator at 703.236.7171 within 48 hours, Monday through Friday, 9:00 am to 4:30 pm.

Tardiness: If you will be arriving late, please call the sleep lab technician at 703.558.6789 after 9:00 pm.

Please retain a copy of your referral/doctor's order and give to the technician prior to your sleep study.

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Welcome to the Sleep Laboratory at Virginia Hospital Center. As part of your clinical evaluation in sleep disorders you have been scheduled for sleep testing at our center. This letter introduces you to our medical director, Dr. Lawrence M. Stein.

Lawrence M. Stein, MD is a graduate of the State University of New York Downstate Medical Center, Brooklyn, New York (MD, 1985). He did his internal medicine training at Columbia Presbyterian Hospital (in NYC) during 1985-1988. Dr. Stein trained in pulmonary and critical care medicine at the Albert Einstein College of Medicine during 1988-1991. He is board certified in Internal Medicine with added qualifications in Pulmonary Disease by the Subspecialty Board. He is also board certified in Critical Care Medicine and Sleep Medicine. A staff member at Virginia Hospital Center, Dr. Stein has his own private practice in Pulmonary and Internal Medicine in Arlington, Virginia.

Your doctor may have referred you for medical consultation or for testing only. A formal medical consultation and examination may be scheduled at your request or at your physician's request. For most patients this has been done before testing. For more information please call 703.236.7171.

**Sleep Laboratory at Virginia Hospital Center
Fact Sheet & Sleep Testing Information**

SLEEP TESTING

PSG: Date _____
Time _____ **AM/PM**

MSLT: Date _____
Time _____ **AM/PM**

SPLIT NIGHT: Date _____
Time _____ **AM/PM**

CPAP: Date _____
Time _____ **AM/PM**

Before your visit, please take the time **at home** to complete the forms that accompany this letter and bring them with you to the center.

1. Sleep history questionnaire
2. Insurance information sheet
3. Insurance card
4. Referral form from your primary physician, if applicable

Directions to Virginia Hospital Center:

From the Capital Beltway (495)

Take Route 66 East to the Washington Boulevard exit. At the traffic light turn left onto Lee Highway. Go approximately 21 blocks to North George Mason Drive. Turn right onto North George Mason Drive and go approximately 5 blocks. Virginia Hospital Center will be on the left.

From Washington, DC

Take Route 66 West to the Glebe Road exit. At the traffic light, turn right onto Glebe Road. Go to the second traffic light and turn left onto 16th Street. Go approximately 7-8 blocks to North George Mason Drive. Turn right onto North George Mason Drive. Virginia Hospital Center will be on the right.

From Route 50

Take Route 50 to the North George Mason Drive exit. Follow North George Mason Drive approximately 10-15 blocks. Virginia Hospital Center will be on the right.

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Instructions for your sleep study

1. Please wash your hair prior to coming to the sleep center. Do not use hair sprays, cream rinses or conditioners. Please do not apply any type of oil-based product to your face or body. Do not apply any makeup or after-shave to your face or body. Please remove any nail polish or artificial nails from at least two fingers.
2. Take your regular medications unless otherwise instructed by your referring Physician. Please record the time all medications were taken the day of the study and submit to the sleep lab technician when you arrive for the study. **Bring all medications that you may need during your stay in the lab.**
3. Please try to get a normal night's sleep the night before your study. Try to maintain your normal sleep patterns, i.e., do not take naps during the day of your study and do not try to stay awake the night before your study.
4. **Do not consume any type of caffeinated or alcoholic beverages the day of your sleep study and limit your total fluid intake after 5:00 PM the evening of your study.**
5. You are required to sleep in nightclothes (e.g., pajamas, gowns, shorts and T-shirts); sleeping in undergarments only is not allowed. Your nightclothes should be loose and, preferably, two-piece. Cotton clothing is preferred. Do not wear anything of a silky nature (silk, satin, nylon, etc.). Please feel free to bring with you any personal belongings that may help you sleep more comfortably (e.g., pillow, blanket, etc.).
6. Please feel free to bring books or magazines with you as aids to help you fall asleep.
7. Bathroom and shower facilities are available for your convenience. However, please bring all the supplies you will need the morning after your sleep study (shampoo, soap, hairdryer, hairspray, shaving cream, razor, toothpaste, toothbrush, personal feminine hygiene items, etc.).
8. If you have been scheduled for an MSLT (Multiple Sleep Latency Test), (daytime sleep study), you may want to prepare your own meals to bring with you. A refrigerator and microwave are available for your use.
9. **All studies will be terminated between 5:00 and 5:30 AM. Departure from the lab will be no later than 6:00 AM.**

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Insurance Information

Policy Holder/Guarantor Information (if different from the patient):

Name: _____ Social Security #: _____/_____/_____

Relationship to patient: _____ Date of Birth: _____

Place of Employment: _____

Primary Insurance: _____

Phone Number: _____

Policy/Member #: _____

Group Number : _____

Claims Address: _____

Name of Policy Holder: _____ Relationship: _____

Secondary Insurance: _____ Phone Number: _____

Policy/Member #: _____ Group #: _____

Claims Address: _____

Name of Policy Holder: _____ Relationship: _____

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Questionnaire

The purpose of this questionnaire is to help our physicians understand the nature of your complaints and possible sleep disorder. This information will be held in the strictest confidence. In order to assist us in serving you better, please answer each question completely and as accurately as possible.

Describe the main reason your study was ordered:

Please answer the following:

	Patient Response	Partner Response, If applicable
How long do you feel you've had a problem with your sleep?		
How many nights a week does your sleep problem affect you?		
On the average, how many hours do you sleep each night?		
How many times do you wake up each night?		
On the average, how long are you awake during the night?		
How long does it normally take you to fall asleep?		
Do you experience the inability to keep your legs still?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have any unusual sleep patterns? Please describe:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you currently working shift work? If yes, please describe:	<input type="checkbox"/> YES <input type="checkbox"/> NO	

Approximately how many ounces of the following beverages/foods do you consume daily?

Coffee: _____ Soft drinks w/caffeine: _____ Chocolate: _____

Alcoholic drinks: _____ Decaf coffee: _____ Tea: _____

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Check any of the following that you feel apply to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Feelings of panic |
| <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Bowel disturbance | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tense feelings |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty with decisions |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Poor home conditions |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Stomach problems |

Answer the following questions utilizing the scale below. Please circle the number that best relates to your symptoms.

Evaluation Scale:

- 1 - No problem, never occurs
- 2 - Mild problem, rarely occurs
- 3 - Moderate problem, happens occasionally
- 4 - Moderately severe problem, occurs frequently
- 5 - Severe problem, occurs frequently

Is your sleep disturbed by any of the following?

- | | |
|--|-----------|
| 1 Sleeping in an unfamiliar bed | 1 2 3 4 5 |
| 2. Asthma | 1 2 3 4 5 |
| 3. Coughing | 1 2 3 4 5 |
| 4 Difficulty breathing in a flat position | 1 2 3 4 5 |
| 5 Awakening due to regurgitation (throat burning, gagging) | 1 2 3 4 5 |
| 6 Urgent need to urinate | 1 2 3 4 5 |
| 7 Nasal congestion or stuffiness | 1 2 3 4 5 |

How much difficulty have you had with the following?

- | | |
|--|-----------|
| 1 Daytime sleepiness; dozing off or struggling to stay awake? | 1 2 3 4 5 |
| 2. Fatigue, exhaustion or lethargy during the day | 1 2 3 4 5 |
| 3. Do you snore while you sleep? | 1 2 3 4 5 |
| 4. Actually falling asleep during the day | 1 2 3 4 5 |
| <i>Sleep partner's response</i> | 1 2 3 4 5 |
| 5 Work/studies compromised because of fatigue or sleepiness | 1 2 3 4 5 |
| <i>Sleep partner's response</i> | 1 2 3 4 5 |
| 6. Falling asleep while operating a motor vehicle | 1 2 3 4 5 |
| <i>Sleep partner's response</i> | 1 2 3 4 5 |
| 7. Accidents as a result of falling asleep while driving | 1 2 3 4 5 |
| <i>Sleep partner's response</i> | 1 2 3 4 5 |
| 8. Feeling sleepy/fatigued after and emotional change (anger/stress) | 1 2 3 4 5 |
| 9 Feeling of weakness after a surprise or emotional change | 1 2 3 4 5 |
| 10. Daytime hallucinations or dreaming | 1 2 3 4 5 |
| 11 Not being able to move when first waking up, despite the feeling of being awake | 1 2 3 4 5 |
| 12. Do you hold your breath, stop breathing, or make "gagging" sounds when sleeping? | 1 2 3 4 5 |
| <i>Sleep partner's response</i> | 1 2 3 4 5 |
| 13 Do you wake up gasping for air or feel unable to breath when sleeping? | 1 2 3 4 5 |

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How likely are you to doze off to fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things 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

Sitting and reading

Watching TV

Sitting, inactive in a public place (e.g. a theater or a meeting)

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 a lunch without alcohol

In a car, while stopped for a few minutes in traffic

Total score

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Phone: 703-236-7171
Fax: 703-236-7172

PATIENT INFORMATION			DATE:		PATIENT'S SOCIAL SECURITY NUMBER
LAST NAME:		FIRST:	MI:	HOME PHONE: () -	
ADDRESS:				WORK PHONE: () -	
CITY:		STATE:	ZIP:	CELL PHONE: () -	
DATE OF BIRTH:		SEX (M/F): _____	EMPLOYED (Y/N) : _____	STUDENT (FT/PT) : _____	
EMPLOYER/SCHOOL NAME:		OCCUPATION:		FAX: () -	
PERSON TO NOTIFY IN CASE OF EMERGENCY:			LAST NAME:		E-MAIL: () -
PERSON TO NOTIFY IN CASE OF EMERGENCY:		LAST NAME:		EMERGENCY NO.: () -	
MARITAL STATUS:	NAME OF SPOUSE:	SPOUSE DATE OF BIRTH:	SPOUSE SOC. SEC.#:	SPOUSE'S PHONE NO.: () -	
RESPONSIBLE PARTY: (If other than Patient)	RELATIONSHIP to Pt.:	RESPONSIBLE PARTY SS #:		RESPONSIBLE PARTY PHONE NO.: () -	
BILLING ADDRESS: (If different from above)					
REFERRED BY OR REFERRING PHYSICIAN:			PRIMARY PHYSICIAN:		
ANY ALLERGIES:			PHARMACY PHONE NO.: () -		

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER:			INSURANCE CARRIER PHONE NO.:		
NAME OF POLICYHOLDER: (If other than Patient)		DATE OF BIRTH: (Policy Holder)		ID OR SOC. SEC. # OF POLICYHOLDER	
POLICY ID:	GROUP NAME:	EFFECTIVE DATE:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF HUSBAND WIFE CHILD OTHER (Please circle appropriate answer)		
SECONDARY INSURANCE CARRIER:			INSURANCE CARRIER PHONE NO.:		
NAME OF POLICYHOLDER: (If other than Patient)		DATE OF BIRTH: (Policy Holder)		ID OR SOC. SEC. # OF POLICYHOLDER	
POLICY ID:	GROUP NAME:	EFFECTIVE DATE:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF HUSBAND WIFE CHILD OTHER (Please circle appropriate answer)		
PERSON TO BE BILLED AFTER INSURANCE IF OTHER THAN SELF:		SOCIAL SECURITY NO.:		ADDRESS:	
DATE OF SERVICE:		PROCEDURE:			
AUTHORIZATION #:					
ADDITIONAL TEST REQUIRED:					

122784-7550-053106

