



The Sleep Center at Greater Baltimore Medical Center  
6701 North Charles St  
Suite 1603, Main Hospital  
Towson, MD 21204  
Phone 443-849-3874 Fax 443-849-6780

Dear Patient,

Thank you for choosing Greater Baltimore Medical Center for your sleep study. This letter is to confirm your scheduled sleep study and to explain what is involved with the procedure.

Arrival Time is **8:45 pm**

**Please note, the Sleep Technologists arrive at 8:45 pm. There is no need to arrive earlier than 8:45 pm, but please be on time.**

**Directions:**

When you enter the hospital campus from Charles Street, make a left at the top of the hill towards the Emergency Department. You will need to park in the **Lily Parking Garage** which is across from the entrance to the Emergency Department. Enter the hospital either by the 3d floor of parking garage or the Emergency Department entrance. Outside of the emergency department is a seating area with a piano. You will also see signs stating **Sleep Study Patient Waiting Area**. Please have a seat and the technologist will be there by 9:00 pm to escort you to the lab.

***Wheelchairs are available at the Emergency Department door if needed.***

**Please keep in mind that sleep study appointments are scheduled in advance. If you are unable to make your appointment, or you have had an insurance change, please contact us at least 48 hours in advance. Please call 443-849-3874.**



## **PATIENT INSTRUCTIONS**

Prepare for your sleep study as if you were spending the night at a hotel. Pack an overnight bag with only items you will need during your stay. 2 Piece pajamas (requested) and toiletries. Please feel free to bring your own pillow or blanket.

### **On the day of your scheduled sleep study:**

- No caffeine after 12:00 pm
- No naps
- No alcoholic beverages
- Eat dinner before arriving
- Wash and dry hair before arriving (no hairspray, gels or oils)
- Remove nail polish and/or acrylics from fingers. This is necessary for accurate oxygen saturation readings during the study.
- Gentlemen should plan on shaving prior to the study. You are not required to remove a mustache or beard. This step is necessary for the attachment of certain leads to your chin.

### **Medications**

- Continue to take any prescription medication unless otherwise instructed by your Physician. If you take any sleeping aids, do not take these until after you arrive at the Sleep Center. Please inform the technician what you are taking.

### **Remember to bring**

- Insurance card
- ID
- Insurance referral, if required
- Medication List, including non-prescription medications
- Completed sleep center paperwork
- Any toiletries you may need
- If requested, favorite pillow/blanket
- Reading material if you like. Each room will also have a television for your convenience.
- Something to eat or drink, if you would like

After the study, please allow 14 days for your Physician to receive the results of your sleep study



### Sleep Assessment Questionnaire

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs Shirt collar size \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

---

#### SLEEP

1. What is your occupation? \_\_\_\_\_
2. What shift do you normally work?  Day  Evening  Night
3. On work days, what time do you Go to bed \_\_\_\_\_ am/pm Wake \_\_\_\_\_ am/pm
4. On weekends, what time do you Go to bed \_\_\_\_\_ am/pm Wake \_\_\_\_\_ am/pm
5. How many hours of sleep do you get each night? \_\_\_\_\_
6. Would you describe yourself as  Night owl  Morning lark  neither
7. Do you have a preferred sleeping position?  Yes  No  
A. If Yes  Right  Left  Back  Prone
8. Do you experience any difficulty falling asleep?  Often  Infrequently  Never  
A. If you experience difficulty falling asleep, how long does it take you to fall asleep? \_\_\_\_\_  
B. How many nights a week do you experience difficulty falling asleep? \_\_\_\_\_
9. On a typical night, approximately:  
A. How many times do you wake after you fall asleep? \_\_\_\_\_  
B. How many times do you wake to use the restroom? \_\_\_\_\_  
C. Other reasons for waking \_\_\_\_\_
10. Do you have difficulty falling back to sleep after you wake up?  Yes  No
11. How long does it usually take you to fall back asleep after you wake? \_\_\_\_\_

#### SNORING

12. Do you snore or has anyone told you that you snore?  Yes  No  
A. If yes:  soft  loud
13. Does your snoring wake you at night?  Yes  No
14. Has anyone ever witnessed that you stop breathing at night?  Yes  No

#### ASSOCIATED COMPLAINTS

15. Do you sometimes wake up with any of the following?  
A. Gasping for air  Yes  No  
B. Chocking  Yes  No  
C. Dry mouth  Often  Rarely  Never  
D. Headache  Yes  No  
E. Chest Pain  Yes  No  
F. Racing heart  Yes  No  
G. Palpatations  Yes  No  
H. Jaw Pain  Yes  No

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

- 16. Do you have any leg discomfort while trying to fall asleep?  Yes  No
- 17. Do you feel the urge to move your legs when at rest or when falling asleep?  Yes  No
- 18. Do you occasionally sleepwalk?  Yes  No
- 19. Do you have frequent nightmares?  Yes  No
- 20. Do you act out your dreams?  Yes  No

**DAYTIME SLEEPINESS**

- 21. Do you feel sleepy during the day?  Yes  No  Sometimes
- 22. Do you take naps?  Yes  No  Sometimes
- 23. Do you feel sleepy when driving?  Yes  No  Sometimes
- 24. Have you ever been in a motor vehicle accident due to sleepiness?  Yes  No  
A. If yes, when \_\_\_\_\_

**MEDICAL HISTORY**

- 25. Have you previously been diagnosed with sleep apnea?  Yes  No
- 26. Have you had a previous sleep study?  Yes  No  
A. If yes, where \_\_\_\_\_ when \_\_\_\_\_
- 27. Do you have any of the following:  
 High blood pressure  Fibromyalgia  Congestive Heart Failure  
 Seizures  Atrial Fibrillation  Head injury or stroke  
 Lung Disease  Diabetes

- 28. List any other major medical problems not listed above \_\_\_\_\_  
\_\_\_\_\_
- 29. List any operations you have had, particularly any involving your nose or throat (including tonsillectomy) \_\_\_\_\_  
\_\_\_\_\_
- 30. List any allergies or allergies to medication you have \_\_\_\_\_  
\_\_\_\_\_
- 31. List current medications

Medication	Dose	Reason For Medication

**OTHER HABITS**

- 32. Do you currently smoke?  Yes  No  
A. Average cigarettes per day \_\_\_\_\_
- 33. Do you have a history of tobacco use?  Yes  No  
A. How many years did you smoke? \_\_\_\_\_
- 34. How many alcoholic beverages do you consume in a week? \_\_\_\_\_
- 35. How many caffeinated beverages do you consume in a week? \_\_\_\_\_



## INSURANCE INFORMATION

We **strongly** encourage you to call your insurance company ahead of time to verify if you are responsible for any copays/deductibles.

A sleep study is a **hospital outpatient diagnostic test**. Please use the following as a reference for sleep study procedure codes when contacting your insurance company.

Diagnostic Sleep Study (Polysomnogram)	CPT 95810
Diagnostic Sleep Study with Nasal CPAP	CPT 95811
Split Night Polysomnogram with CPAP	CPT 95811
Multiple Sleep Latency Test	CPT 95805

The GBMC Sleep Lab will verify with your insurance program for authorization; however, some insurance providers require a Physicians referral. Obtaining the referral is the responsibility of the patient. If a referral is required, you must bring with you the night of your sleep study. If a referral is required and the patient does not bring to the sleep study, we will need to reschedule.

**IF YOUR INSURANCE WILL CHANGE BEFORE YOUR SCHEDULED SLEEP STUDY YOU MUST NOTIFY THE SLEEP LAB PRIOR TO YOUR STUDY IN ORDER FOR US TO REQUEST NEW AUTHORIZATION. IN THE EVENT WE ARE NOT NOTIFIED, THE FINANCIAL RESPONSIBILITY WILL FALL TO THE PATIENT FOR FULL COST OF STUDY.**