

**Welcome to the UCLA Sleep Disorders Center**  
**Our Sleep Center Website is: <http://sleepcenter.ucla.edu>**

**Sleep Study for:** \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_ **Mon Tue Wed Thu Fri Sat Sun** at **8:30PM -6:00AM** (Next Day)

**Check in at:** **FRONT DESK (Visitor Lot 27)**

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Your sleep study appointment is scheduled for **8:30 PM**. Please feel free to arrive up to **15** minutes early for your appointment. Patients arriving after **8:45 PM** may need to be rescheduled. We do need a 48 hour confirmation call, If you need to cancel your appointment, kindly call **48 hours in advance**.

If your study requires COVID TEST SCHEDULING 1-2 days prior, call (310) 481-0423.

**Insurance:** authorizations must be processed prior to scheduling a sleep study appointment through your referring Doctors office. Even though you will be spending the night in the sleep center, the sleep study is considered an outpatient procedure.

For questions about insurance coverages, copayments, or billing, please contact your insurance representative to determine your personal coverage. Your insurance carrier will be billed for technical (the test) and professional (the interpretation) services; however, services not covered or remaining balances will be your financial responsibility.

Please bring your insurance card(s) and/or insurance authorization number(s) if applicable.

**Enclosed you will find the following:**

- Directions to the Sleep Disorders Center
- Parking information
- How to prepare and what to bring to your sleep study
- What to expect during your sleep study
- A sleep questionnaire

**Please complete every page of the attached packet and bring it with you to your appointment.**

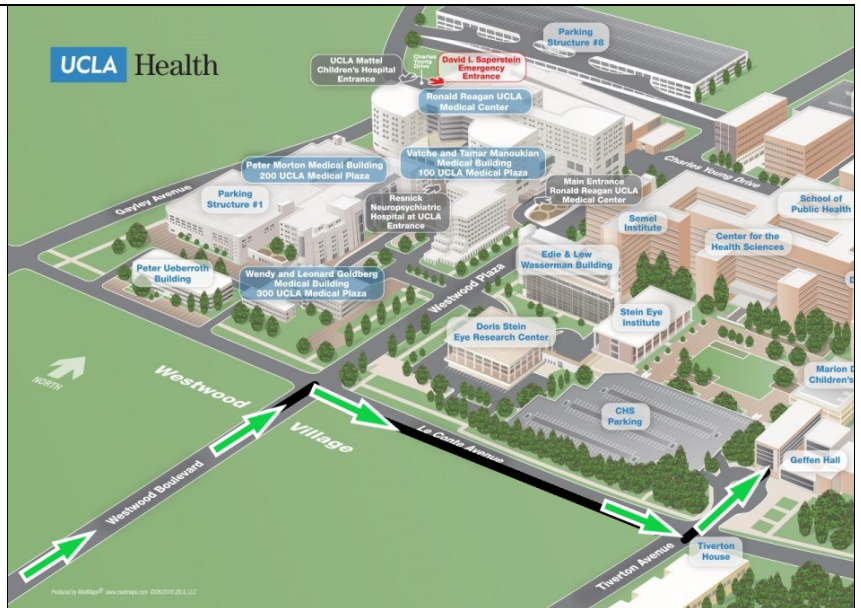
Our department has earned an outstanding reputation in subspecialty care of sleep disorders due to a high level of clinical expertise, academic achievement and innovative research. Our most important mission is to provide each patient with the best sleep medicine health care available by combining our extensive experience with the latest advances in the treatment of sleep disorders. Our faculty and staff work together as a team to bring each patient the highest quality of care in a warm, friendly and professional environment.

We look forward to caring for you.

Sleep Center Staff

## Directions from the 405 Freeway

- Take the Wilshire Blvd East Exit (WESTWOOD)
- Turn Left on Westwood Blvd
- Turn Right on Le Conte Ave
- Turn Left at the Tiverton Ave Light
- Enter Straight into Geffen Hall Tunnel
- Turn Right to Visitor Parking Lot #27



- Stay STRAIGHT to enter the TUNNEL towards the Patient and Visitor Parking (Lot 18 & 27)



- Turn RIGHT at the stop sign to enter the Patient and Visitor Parking Lot 27 for CTRC/Sleep Center Parking.



Once parked, go to the pay station.

Remember your license plate number.

Follow instructions on keypad, entering your license plate number.

Pay using EXACT cash amount or with credit card or download the **ParkMobile** app on your phone. <https://parkmobile.io/>

Pay station only accepts \$1 & \$5 bills only. It **DOES NOT** give change in the form of cash or credit.

You have arrived at

**Clinical and Translational Research Center (CTRC)**

**UCLA Sleep Disorders Center**

Proceed to the glass ENTRANCE doors in Lot #27

### Parking Fees

- All Day \$13
- All Night \$8
- 2 Day Pass \$20
- 3 Hours \$9
- 2 Hours \$6
- 1 Hour \$3



## How to Prepare and What to Bring

### How to Prepare

- Please arrive with clean, dry, hair and refrain from using any products such as hair spray, oils, or dyes.
- Please note that sensors will need to be placed on the scalp during the study, so any type of artificial hair may interfere with sensor placement.
- Nail polishes and false nails are not advised.

### Items to Bring

- Your completed Questionnaires
- Medications – please bring your medications for technologist are unable to provide medications during your study.
- Pajamas or a two-piece outfit to wear to sleep
- Toiletries (toothbrush, toothpaste, contacts solution, etc.)
- Shoes, slippers or sandals to go to the bathroom
- Although we provide Pillows and Blankets, you may bring your own favorite Pillow, Blankets or other items to make your sleep more comfortable.
- If you wear a CPAP or Bi-level mask at home, you may bring it with you.
- If you use a dental device to treat sleep apnea, please bring it with you.

### For patients scheduled for additional recordings the following day:

*Please plan on bringing food for breakfast and lunch with you. Once you are set up for your sleep study at night, you will not be able to leave the premises to purchase food. We do not have a refrigerator to store food, please use a lunch box or cooler.*

## What to Expect During Your Study

We strive to make your stay at the Sleep Center as comfortable as possible, but your patience and understanding during the night is also greatly appreciated. While we strive to make this experience as comfortable as possible, please be advised that this is a hospital-based facility. Our beds are single hospital style beds complete with bedrails to provide extra safety for our patients. Each room has its own sink, mirror, and television for your convenience.

Upon arrival at your scheduled appointment time, you will be checked in by one of the technologists and shown to your room.

Once in your room, your technologist will discuss the specifics of your personal sleep study and collect any additional information if needed. Typically, the technologist will begin the process of the sleep study between 8:45 pm to 10:00 pm, depending upon patient arrivals and the study type your specific start time may vary slightly. Except for using the restroom, you will be required to stay in bed resting quietly during the study, even if you are awake.

The application of the sensors and monitors is painless and safe. Hypoallergenic products are used during the sleep study, but please advise your technologist of any allergies or sensitivities prior to the start of the study. We will be monitoring your brainwaves, breathing, heart rhythm, oxygen saturation, and muscle movements. Occasionally, once the study has started, a technologist may need to enter the room to reposition or replace sensors. For some patients, PAP therapy may be part of the sleep study, but your technologist will advise you if this is part of your study prior to starting. The technologist who removes the sensors at the end of the study may not be the same person who applied them. Normal wake-up time is 5:30AM. You will be able to leave by 6:00AM the following morning if not scheduled for additional recordings.

Video and audio monitoring is performed during the sleep study. Recordings are used by the Sleep Specialist Physicians ONLY. These recordings are not available for transfer or copy. **Please refrain from taking any personal photos or videos once in the testing area. We thank you in advance for respecting the privacy of other patients and sleep center staff.**

The technologists are highly trained and knowledgeable; however, they may not give you any results or other information regarding your sleep study or medical conditions. Sleep studies are highly specialized medical procedures that require time and care to perform and analyze. Results of the study will typically be available within approximately two weeks. Please contact the physician who ordered your sleep study for follow-up and results. If you wish to obtain a copy of your report, please contact the Medical Records Department at 310-825-6022.

MRN:  
Patient Name:  
  
(Patient Label)

**SLEEP QUESTIONNAIRE**  
**SLEEP DISORDERS CLINIC / CENTER**

**Marital Status:**

- Single     Married     Divorced     Widow(er)     Separated     Living together

**Occupation:** \_\_\_\_\_

My main complaint is:

- Trouble sleeping at night     Being sleepy all day     Unwanted behaviors during sleep

Explain: \_\_\_\_\_

Other (explain): \_\_\_\_\_

**Usual Sleep Habits:**

Bedtime: \_\_\_\_\_  am  pm    Number of awakenings: \_\_\_\_\_    Height: \_\_\_\_\_  
Wake time: \_\_\_\_\_  am  pm    Number of naps/week: \_\_\_\_\_    Weight: \_\_\_\_\_  
Duration of sleep problem: \_\_\_\_\_

**Directions:** Check any statement which currently applies to you:

- |  |   |
|--|---|
| <input type="checkbox"/> Un-refreshing naps                                    | <input type="checkbox"/> Dreams or hallucinations while awake           |
| <input type="checkbox"/> Dream a lot   | <input type="checkbox"/> Sudden feeling of weakness in knees or legs    |
| <input type="checkbox"/> Was a hyperactive child or teenager                   | <input type="checkbox"/> Difficulty waking up in the morning            |
| <input type="checkbox"/> Use sleeping pills                                    | <input type="checkbox"/> Function best in the morning                   |
| <input type="checkbox"/> Bed partner disturbs sleep                            | <input type="checkbox"/> Don't feel tired at bedtime                    |
| <input type="checkbox"/> Heart pain during the night                           | <input type="checkbox"/> Shift-worker or night worker                   |
| <input type="checkbox"/> Awaken with back pain                                 | <input type="checkbox"/> Restlessness, tingling or crawling in legs     |
| <input type="checkbox"/> Restless sleeper                                      | <input type="checkbox"/> Sleep talking as adult                         |
| <input type="checkbox"/> Trouble falling asleep                                | <input type="checkbox"/> Banging, twisting or shaking head in sleep     |
| <input type="checkbox"/> Awaken long time before it is necessary               | <input type="checkbox"/> Sudden awakening with intense anxiety or dread |
| <input type="checkbox"/> Sleep better in unfamiliar setting                    | <input type="checkbox"/> Grind teeth in sleep                           |
| <input type="checkbox"/> Light sleeper   | <input type="checkbox"/> Sleepwalking as an adult                       |
| <input type="checkbox"/> Trouble returning to sleep                            | <input type="checkbox"/> Bedwetting in adulthood                        |
| <input type="checkbox"/> Stop breathing during sleep                           | <input type="checkbox"/> Awaken with heartburn                          |
| <input type="checkbox"/> Gained more than 10lbs. In the last year              | <input type="checkbox"/> Cough up sputum or mucus at night              |
| <input type="checkbox"/> Unable to sleep in a flat position                    | <input type="checkbox"/> Kicking or twitching during sleep              |
| <input type="checkbox"/> Jaws ache in the morning                              | <input type="checkbox"/> Legs jerk during sleep                         |
| <input type="checkbox"/> Bitter or sour mouth taste in the morning             | <input type="checkbox"/> Experience inability to keep legs still        |
| <input type="checkbox"/> Very loud snorer                                      | <input type="checkbox"/> Nocturnal seizures                             |
| <input type="checkbox"/> Awaken with headaches                                 | <input type="checkbox"/> Bitten tongue during sleep                     |
| <input type="checkbox"/> Have high blood pressure                              | <b>Women</b>  |
| <input type="checkbox"/> Awaken with choking sensation                         | <input type="checkbox"/> Sleep problem varies with menstrual cycle      |
| <input type="checkbox"/> Driving accidents or near-accidents due to sleepiness | <input type="checkbox"/> Sleep problem started/worsened at menopause    |
| <input type="checkbox"/> Paralysis or inability to move on awakening           | <input type="checkbox"/> Currently taking hormonal pills                |
| <input type="checkbox"/> Driven miles past destination with little awareness   | <b>Men</b>  |
| <input type="checkbox"/> Falling asleep at inappropriate times                 | <input type="checkbox"/> Awaken with painful penile erections           |
| <input type="checkbox"/> Refreshing naps                                       | <input type="checkbox"/> Problems obtaining/maintaining erections       |

**SLEEP QUESTIONNAIRE  
SLEEP DISORDERS CLINIC / CENTER**

MRN:  
Patient Name:  
  
(Patient Label)

**Epworth Sleepiness Scale**

The Epworth Sleepiness Scale (ESS) is a standardized self-administered 8-item questionnaire commonly used to assess sleepiness.

**Patients are given the following instructions:**

The questionnaire asks you to rate the chances that you would doze off or fall asleep during different routine situations. Answers to the questions are rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high likelihood that you would doze or fall asleep in that situation.

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**

	<u>Chances of dozing</u>			
	<b>Never (0)</b>	<b>Slight (1)</b>	<b>Mod (2)</b>	<b>High (3)</b>
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive, in a public place ( <i>e.g. a theater or meeting</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SLEEP QUESTIONNAIRE**  
**SLEEP DISORDERS CLINIC / CENTER**

MRN:  
 Patient Name:  
  
 (Patient Label)

**Daily Sleep Log**

To help us understand your sleep problems, we need a report of the times when you sleep, nap and wake-up during sleep. In addition, we need to know the times when you drink coffee, tea and alcoholic beverages. If medication is taken, record the time medication is needed. It is important that you keep this record for 7 days. Each column begins with a new day. The first column is an example for you to study. If you have any questions, call the UCLA Sleep Disorders Center. "A" indicates AM (morning). "P" indicates PM (afternoon or evening).

<b>DATE: <i>Please be sure to write the date</i></b>	<b>Example: 10/7</b>	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>	<b>Day 6</b>	<b>Day 7</b>
Bedtime	11:00 PM							
Estimated time it took to fall asleep	45 min.							
Time of awakenings during sleep and length of time you were awake	2 A – 1 hr 3 A – 1 hr							
Time of final awakening in the morning	5:30 AM							
Total night's sleep	3 hrs							
Naps, times you napped and, length of naps	2 P 45 min.							
Medications taken, times and amounts	Dalmane 80 mg 10:30 PM							
Coffee and tea, number of cups and time drank	7:00A – 1							
Alcoholic drinks, number and time drank	8:00P – 1 9:00P – 1 10:00P – 1							

Evening activities for each day:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

**SLEEP QUESTIONNAIRE  
SLEEP DISORDERS CLINIC / CENTER**

MRN:  
Patient Name:  
  
(Patient Label)

**Patient Health Questionnaire (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

<i>(Please check to indicate your answer)</i>	Not at all (0)	Severa l days (1)	More than half the days (2)	Nearly every day (3)
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Score _____ =</b>	_____	_____	_____	_____

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all     Somewhat difficult     Very difficult     Extremely difficult

Total PHQ – 9 Score: \_\_\_\_\_

Patient or Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

If signed by someone other than the patient, please specify relationship to the patient: \_\_\_\_\_

Physician Signature \_\_\_\_\_ ID # \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Interpreter Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_



MRN:  
Patient Name:  
  
(Patient Label)

**SPOUSE OR ROOMMATE QUESTIONNAIRE  
SLEEP DISORDERS CENTER**

**To be completed by Bed – Partner, Family member or Roommate**

Check any of the following behaviors that you have observed the patient do while he/she is asleep:

- |   |   |
|---|---|
| <input type="checkbox"/> Loud snoring                           | <input type="checkbox"/> Bed wetting                          |
| <input type="checkbox"/> Light snoring                          | <input type="checkbox"/> Sitting up in bed but not awake      |
| <input type="checkbox"/> Twitching of legs or feet during sleep | <input type="checkbox"/> Head rocking or banging              |
| <input type="checkbox"/> Pause in breathing                     | <input type="checkbox"/> Kicking with legs during sleep       |
| <input type="checkbox"/> Grinding teeth                         | <input type="checkbox"/> Getting out of bed but no awake      |
| <input type="checkbox"/> Sleep talking                          | <input type="checkbox"/> Biting tongue                        |
| <input type="checkbox"/> Sleep walking                          | <input type="checkbox"/> Becoming very rigid and / or shaking |
| <input type="checkbox"/> Pause in breathing                     |   |

How long have you been aware of the sleep behavior(s) checked above?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, it's frequency during the night, and whether it occurs every night.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you heard loud snoring, do you remember hearing short pauses in the snoring or occasional loud "snorts"?  Yes  No

Describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient or Representative Signature \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

If signed by someone other than the patient, please specify relationship to the patient: \_\_\_\_\_

Interpreter Signature \_\_\_\_\_ ID # \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_