Welcome to the UCLA Sleep Disorders Center
Our Sleep Center Website is: [http://sleepcenter.ucla.edu](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)

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

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

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>Chances of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Watching TV</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Sitting inactive, in a public place <em>(e.g. a theater or meeting)</em></td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
</tbody>
</table>
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).

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

Evening activities for each day:
1. ____________________________________________
2. ____________________________________________
3. ____________________________________________
4. ____________________________________________
5. ____________________________________________
6. ____________________________________________
7. ____________________________________________
Patient Health Questionnaire (PHQ-9)

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

(Please check to indicate your answer) | Not at all (0) | Several days (1) | More than half the days (2) | Nearly every day (3)
---|---|---|---|---
Little interest or pleasure in doing things | | | | |
Feeling down, depressed, or hopeless | | | | |
Trouble falling or staying asleep, or sleeping too much | | | | |
Feeling tired or having little energy | | | | |
Poor appetite or overeating | | | | |
Feeling bad about yourself or that you are a failure, or have let yourself or your family down | | | | |
Trouble concentrating on things, such as reading the newspaper or watching television | | | | |
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 | | | | |
Thoughts that would be better off dead or of hurting yourself in some way | | | | |

Score =

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 ________
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:

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

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 _________________