Sleep Disorders Center
10833 Le Conte Ave., BE Level
Los Angeles, CA 90095
310-26-SLEEP (7-5337)

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)**

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

UCLA Health System

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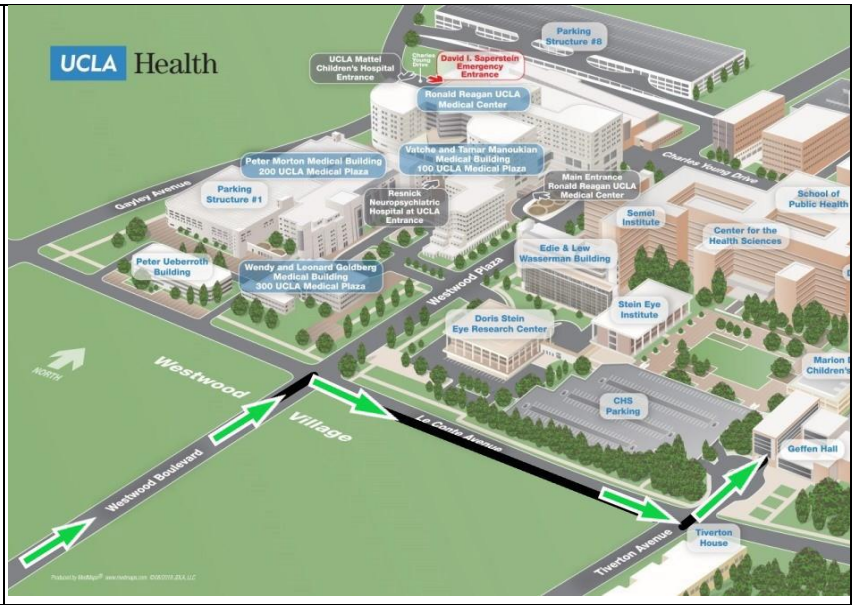
Directions from the *405 Freeway*

- 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.**

For 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 $17
All Night $12
3 Hours $13
2 Hours $9
1 Hour $5

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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.

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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.

UCLA Health

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:

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

Women
☐ Sleep problem varies with menstrual cycle
☐ Sleep problem started/worsened at menopause
☐ Currently taking hormonal pills

Men
☐ Awaken with painful penile erections
☐ Problems obtaining/maintaining erections

UCLA Health

MRN:
Patient Name:

(Patient Label)

SLEEP QUESTIONNAIRE
SLEEP DISORDERS CLINIC / CENTER

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

	Chances of dozing			
SITUATION	**Never (0)**	**Slight (1)**	**Mod (2)**	**High (3)**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive, in a public place *(e.g. a theater or 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	☐	☐	☐	☐

UCLA Health

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Patient Name:

(Patient Label)

SLEEP QUESTIONNAIRE
SLEEP DISORDERS CLINIC / CENTER

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).

DATE: *Please be sure to write the date*	**Example: 10/7**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**	**Day 7**
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. _____

UCLA Health

MRN:
Patient Name:

(Patient Label)

SLEEP QUESTIONNAIRE
SLEEP DISORDERS CLINIC / CENTER

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 _____

UCLA Health

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:

- ☐ 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 _____