

Your Journey Into Sleep-Home Study (Level 3)

WRHA Sleep Disorder Centre

***Please take the time to read these instructions**

A Home Study is a diagnostic test which is performed in your own home, if your physician suspects that you have Obstructive Sleep Apnea.

A Home Study uses simple, comfortable and user friendly monitoring equipment to study your breathing during sleep in the comfort of your own home.

Finding the Sleep Disorder Centre

1. Misericordia-99 Cornish Avenue Entrance:

Enter through the Misericordia 99 Cornish Avenue entrance.

Proceed to Elevator D. Take Elevator D to the Sleep Disorder Centre. As you exit Elevator D turn right and report to the Reception Desk.

2. Parkade (located on Sherbrook Street)

Enter through the Parkade overpass and take Elevator B to the Main Floor. Exit Elevator B to your right and proceed to Elevator D. Take Elevator D to the Sleep Disorder Centre. As you exit Elevator D turn right and report to the Reception Desk.

Additional Information Required

It is important to complete the enclosed forms and bring completed forms to the Home Study training session:

- Patient Sleep History Questionnaire
- Sleep Apnea Quality of Life Index (SAQLI)

Training Session

Please arrive 15 minutes prior to your appointment and give the clerk your Patient Sleep History and Sleep Apnea Quality of Life Index (SAQLI) paperwork.

The Home Study training session will be approximately 90 minutes in total.

The training session will be conducted in a group setting of 2-6 people. A 5-10 minute video describing Sleep Apnea and its symptoms will be presented, along with step by step instructions on how to apply the testing equipment at home.

After the group training session is complete you will see the Registered Respiratory Therapist in a private one-on-one session to gather measurements. The Registered Respiratory Therapist will review all testing equipment that you will take home with you.

Please make sure you understand all instructions before you leave your appointment.

Returning of Testing Equipment

We would kindly ask that you bring back the equipment the following business day promptly between 8:00 and 10:00 a.m. so we can retrieve the data and prepare the equipment for the next training session. If the training session is on a Friday the equipment can be returned on the weekend after 8:30 PM or Monday morning.

It is important that you complete and return your **Sleep Study Diary** with your testing equipment.

Your results will be discussed with you at a follow up appointment with a Sleep Physician. The date and time of your appointment is included in this package.

If you MUST cancel your appointment, we require at least 24-48 hours notice.

Contact us...

If you have any questions, our phone number is 204-788-8570.

Sleep Disorder Centre Patient Sleep History

In order that we may process your referral on a timely basis, please ensure that you have completely filled out the following information. Failure to complete each section may result in a delay in providing your appointment.

All data is confidential and no patient identifiers are used.

*Do you consent to this clinical information and/or your sleep study data being used for research purposes? Yes No

Today's Date: _____

First Name: _____ Last Name: _____

Date of Birth: _____
 dd mm yyyy

Health Card:

MB Health# (6 digit): _____ PHIN# (9 digit): _____

| | Yes | No | Number |
|-------------------|--------------------------|--------------------------|--------|
| RCMP | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Canadian Military | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Out of Province | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Aboriginal Treaty | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Do you live on a Reserve? Yes No

Home Address/Postal Code: _____

Phone Numbers:

Home#: _____ Cell#: _____ Work#: _____ Message#: _____

Weight: _____ Height: _____

Referring Physician: _____ Family Physician: _____

What are your major concern(s) regarding your sleep? (check all that apply):

- Difficulty falling asleep
- Difficulty staying asleep
- Non-refreshing, broken sleep
- Feeling sleepy during the day
- Feeling very tired during the day
- Difficulties breathing in my sleep
- Snoring and/or stopping breathing bothers my partner
- Urge to move my legs at night
- Strange behavior in my sleep (excess movement, sleep walking, etc.)
- Pain disrupts my sleep
- Other: _____

Highest Education Level: High School Post-Secondary

Type of Occupation: (check any that apply)

- Drivers who admit they have fallen asleep driving, within the last 2 years
- Work with Machinery, Hazardous Occupation
- Commercial Driver
- Railway Engineer
- Pilot
- Air Traffic Controller, Airplane Mechanic
- Ship Captain
- Health Care Occupation
- Child Care Occupation

Evening/Night Shift(s)? Yes No

Do you operate heavy/dangerous equipment/transport vehicles (tractor, bus, ambulance)? Yes No

Please answer the following questions as completely as possible.

How likely are you to doze off or 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.

Using the following scale, circle the *most appropriate number* for each situation:

0 = would *less than once a month* doze

1 = *slight* chance of dozing

2 = *moderate* chance of dozing

3 = *high* chance of dozing

| Situation | Chance of Dozing |
|--|-------------------------|
| Sitting and reading | 0 1 2 3 |
| Watching television | 0 1 2 3 |
| Sitting, inactive in a public place (in a theatre or in a meeting) | 0 1 2 3 |
| As a passenger in a car for an hour without a break | 0 1 2 3 |
| Lying down to rest in the afternoon (when circumstances permit) | 0 1 2 3 |
| Sitting and talking to someone | 0 1 2 3 |
| Sitting quietly after lunch without alcohol | 0 1 2 3 |
| In a car, while stopped for a few minutes in the traffic | 0 1 2 3 |

Total: _____/24

- 1) Are your sleep problems affecting your quality of life? Yes No
 If yes, is this effect: mild moderate severe
- Memory Problems? Yes No
 Problems Concentrating? Yes No
 Irritability? Yes No
- 2) Because of your sleep problems, have you:
- Considered (or are on) disability? Yes No
 Had work (or school) difficulties? Yes No
 Had motor vehicle accidents? Yes No
 Had driving problems? Yes No
- 3) Do you feel rested when you awaken for the day? Yes No
- 4) Do you feel that you are more tired during the day than you should be? Yes No
- 5) Do you get strong urges to fall asleep during the day? Yes No
- 6) Do you fall asleep unintentionally during the day? Yes No
 If yes, does this occur while you are:
- Inactive or bored? Yes No
 Active or engaged in interesting activities? Yes No
- 7) Do you nap during the day? Yes No
 If yes: How often? _____ times per day/week/month.
 How long? _____ minutes/hours.
- Are the naps refreshing? Yes No
- 8) How many nights a week do you have sleep problems? _____ nights.
- 9) What time do you go to bed during the week? _____ PM/AM.
 On the weekend? _____ PM/AM.
- 10) How long does it take you to fall asleep at night? _____ minutes.
- 11) What time do you get up during the week? _____ PM/AM.
 What time do you get up on the weekends? _____ PM/AM.
- 12) On average, how often do you wake up during the night? _____ times.
 How long does it take you to return to sleep? _____ minutes.
- During the past month, how many nights per week did you spend at least one hour awake after falling asleep? Less than 3 3-5 6-7

- 13) How long do you sleep for on an average night? _____ hours.
- 14) How much sleep do you feel you need? _____ hours.
- 15) Do you snore? Do not know Yes No
 If yes,
- A) How often do you snore? (check one)**
- Every night
 - Most (>50%) of nights
 - Some (<50%) of nights
 - Very rarely or not at all
- B) How long do you snore? (check one)**
- All night
 - Most (>50%) of nights
 - Some (<50%) of nights
 - Hardly or not at all
- C) How audible is your snoring (with the door shut)? (check one)**
- Can be heard down the hall
 - Can be heard in the next room
 - Can be heard in the same room
 - Barely audible
- 16) Have you awakened during the night choking? Yes No
- 17) Do you ever wake up with an acidic taste in your mouth? Yes No
- 18) Do you ever wake up with your heart racing? Yes No
- 19) On average,
 how many times do you get up to go to the bathroom during the night? _____ time(s).
- 20) Do you awaken in the morning with a dry mouth or cough? Yes No
- 21) Have you gained weight in the last 5 years? Yes No
 If yes, how much? _____
- 22) Do you have morning headaches? Yes No
 If yes, how many days a week? _____ days.

- 23)** Do you have any of the following?
 Frequent nasal congestion Yes No Tonsillectomy Yes No
 Blocked nasal passages Yes No Nose injury Yes No
 Previous use of CPAP? Yes No False teeth/dentures? Yes No
 Previous operation for sleep apnea? Yes No
 Previous use of an oral appliance? Yes No
- 24)** Is there a family history of sleep disorders, such as snoring, sleep apnea, narcolepsy, or excessive daytime sleepiness (circle disorder if yes)? Yes No
- 25)** Do you take medication or alcohol to sleep better? Yes No
- 26)** How many alcoholic drinks do you have on weekdays? _____ on weekends? _____
- 27)** How many caffeine-containing drinks do you consume per day?
 _____ cups of coffee _____ cola drinks _____ other caffeine drinks
- 28)** Do you smoke? Yes No (former smoker) No (never)
 If yes, how much per day? _____ cig./packs.
- 29)** Do you kick during sleep? Yes No
 Does your body jerk during sleep? Yes No
- 30)** Do you have uncomfortable leg sensations (burning, aching, creeping, crawling), that gets worse with rest and better with movement resulting in a need to move your legs? Yes No
 If yes, do these sensations interfere with your sleep? Yes No
- This occurs: every night 3-5 times/week 1-2 times/week less than once/week
- 31)** Have you ever felt “paralyzed” while falling asleep or waking up? Yes No
- 32)** Have you ever had vivid dreams or “hallucinations” while falling asleep or waking up? Yes No
- 33)** Have you ever collapsed, or lost muscle strength? Yes No
 If yes, did these episodes come on after experiencing a sudden emotion such as anger, joy or surprise? Yes No
- 34)** Do you have nightmares or terrifying experiences at night? Yes No
- 35)** Do you talk in your sleep? Do not know Yes No
- 36)** Do you sleep-walk? Yes No
- 37)** Has anyone observed you to have unusual movements or behavior in your sleep? Yes No
- 38)** Do you eat in your sleep? Yes No

Patient Medical History

Have you ever been diagnosed with: (Please √ Yes or No)

| | On Medications for: | | | |
|--------------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|
| A. High blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Atrial fibrillation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arrhythmia? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ICD? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling in your ankles? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congestive Heart Failure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angina? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart murmur? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Cholesterol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pre or Post Menopausal? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Is there a family history of developing heart attacks or strokes in a direct family member less than 50 years of age? Yes No

| | | | | |
|------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|
| B. Head injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Frequent headaches? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Epilepsy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Arthritis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fibromyalgia? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Do you wake up at night from pain or does it prevent you from falling asleep? Yes No Yes No

| | | | | |
|--------------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|
| D. Depression problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anxiety? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Panic attacks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychiatric treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Previous Drug Abuse? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| E. Kidney disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emphysema? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypothyroidism? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hyperthyroidism? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

F. Describe any medical problems not listed on the previous page:

G. List all medicines and pills that you are taking (name/dosage):

H. List any drugs or medicines you are allergic to:

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM

Name: _____

Date: _____

SLEEP APNEA QUALITY OF LIFE INDEX (SAQLI)

We would like to understand the impact that sleep apnea and/or snoring have had on your daily activities, emotions, social interactions, and about symptoms that may have resulted.

1. How much have you had to push yourself to remain alert during a typical day (e.g. work, school, childcare, housework?)

- not at all
- a small amount
- a small to moderate amount
- a moderate amount
- a moderate to large amount
- a large amount
- a very large amount

2. How often have you had to use all your energy to accomplish your most important activity (e.g. work, school, childcare, housework?)

- never
- a small amount of the time
- a small to moderate amount of the time
- a moderate amount of the time
- a moderate to large amount of the time
- a large amount of the time
- a very large amount of the time

3. How much difficulty have you had finding the energy to do other activities (e.g. exercise, relaxing activities?)

- no difficulty
- a small amount
- a small to moderate amount
- a moderate amount
- a moderate to large amount
- a large amount
- a very large amount

4. How much difficulty have you had fighting to stay awake?

- no difficulty
- a small amount
- a small to moderate amount
- a moderate amount
- a moderate to large amount
- a large amount
- a very large amount

SAQLI page 2

5. How much of a problem has it been to be told that your snoring is irritating?

- no problem
- a small problem
- a small to moderate problem
- a moderate problem
- a moderate to large problem
- a large problem
- a very large problem

6. How much of a problem have frequent conflicts or arguments been?

- no difficulty
- a small amount
- a small to moderate amount
- a moderate amount
- a moderate to large amount
- a large amount
- a very large amount

7. How often have you looked for excuses for being tired?

- never
- a small amount of the time
- a small to moderate amount of the time
- a moderate amount of the time
- a moderate to large amount of the time
- a large amount of the time
- a very large amount of the time

8. How often have you not wanted to do things with your family and/or friends?

- never
- a small amount of the time
- a small to moderate amount of the time
- a moderate amount of the time
- a moderate to large amount of the time
- a large amount of the time
- a very large amount of the time

9. How often have you felt depressed, down, or hopeless?

- never
- a small amount of the time
- a small to moderate amount of the time
- a moderate amount of the time
- a moderate to large amount of the time
- a large amount of the time
- a very large amount of the time

SAQLI page 3

10. How often have you been impatient?

- never
- a small amount of the time
- a small to moderate amount of the time
- a moderate amount of the time
- a moderate to large amount of the time
- a large amount of the time
- a very large amount of the time

11. How much of a problem has it been to cope with everyday issues?

- no problem
- a small problem
- a small to moderate problem
- a moderate problem
- a moderate to large problem
- a large problem
- a very large problem

12. How much of a problem have you had with decreased energy?

- no problem
- a small problem
- a small to moderate problem
- a moderate problem
- a moderate to large problem
- a large problem
- a very large problem

13. How much of a problem have you had with fatigue?

- no problem
- a small problem
- a small to moderate problem
- a moderate problem
- a moderate to large problem
- a large problem
- a very large problem

14. How much of a problem have you had waking up feeling unrefreshed?

- no problem
- a small problem
- a small to moderate problem
- a moderate problem
- a moderate to large problem
- a large problem
- a very large problem