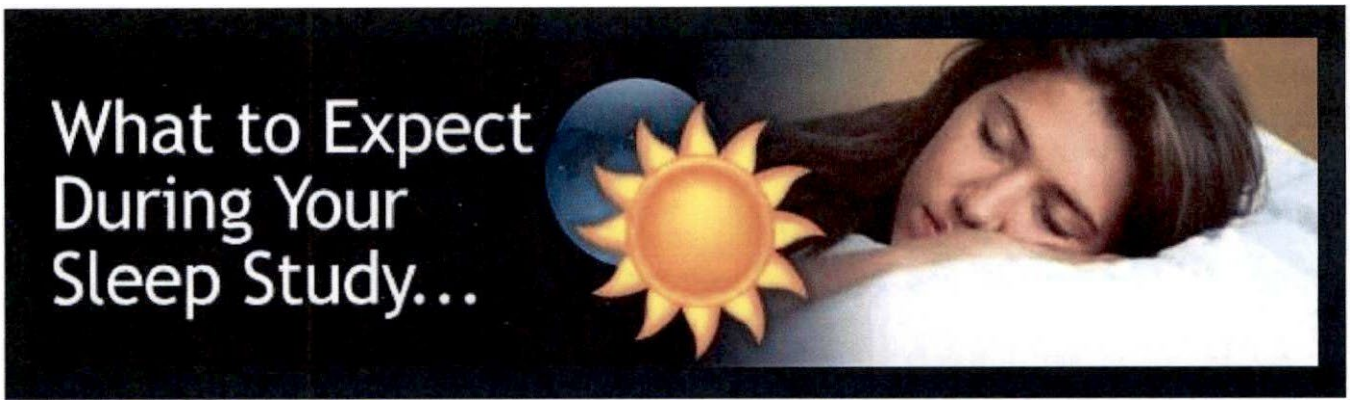
SLEEP DIAGNOSTIC AND TREATMENT CENTER

A DIVISION OF THE NEUROLOGY CENTER OF FAIRFAX, LTD.



What is a sleep study?

A sleep study (or polysomnogram) records 16 different measurements of your brain and body while you sleep. This test is not invasive. The study uses electrodes (sensors) which are attached to the skin by a special adhesive or tape. No needles! The test begins at night and lasts to the morning, as would a normal night of sleep.

What should I bring with me?

Prepare yourself for your night in the sleep laboratory as if you were going to spend a night at a hotel. Please bring with you everything you would need to spend the night away from home. This should include: **all medications**, comfortable clothes to sleep in, and your toiletries. If you wish, you may bring your own pillow. Please keep in mind that cell phones should be turned off at night to prevent disruption to you and the other guests.

What happens when I get to the sleep center?

Please arrive at the sleep laboratory between 8:30 and 8:45 PM. You will need to press the after-hours Neurology Center buzzer at the main doors to the building on Hamaker Court to obtain entry for your study. You will be greeted by a sleep technologist and provided instructions on what to do.

What information do the sensors provide?

From the sensors/electrodes that are placed on the body, we can measure an extensive amount of physiologic data. These include:

- **Brain waves and sleep stages.** Usually 6 electrodes are attached to your scalp with a water-soluble paste or adhesive. Your hair is not cut or shaved.
- **Eye Movements.** 2 or 3 electrodes are attached with tape near your right and left eyes. They do not touch your eye in any way. Eye movements help us identify the different stages of sleep.
- **Muscle Activity.** 2 or 3 electrodes are attached with tape to your chin. Muscle activity around the chin can indicate teeth clenching/grinding. It also helps us determine which stage of sleep you are in.
- **Electrocardiogram (ECG).** 3 electrodes are attached with tape to your upper chest to record your heart's rhythm and activity.
- **Leg Movements.** A small belt or cuff is placed around each ankle to record leg movements. Occasionally, 2 electrodes are attached with tape to your lower legs to measure leg muscle activity.
- **Breathing.** Your breathing is measured in several ways. A sensor is attached with tape to your upper lip to measure airflow. Lightweight belts are placed around the chest and abdomen to measure your breathing effort.
- **Oxygen level.** A sensor is attached to one of your fingers or your ear with tape to measure the oxygen level in your blood at all times.

- **Other** sensors. Depending on your particular problem, other types of sensors may be used. Please feel free to ask the technologist about any of the equipment used in the sleep laboratory.

Why is it necessary to record all this data?

Your brain and body function very differently during the day and at night. Even if your heart function, breathing, and brain activity are completely normal during the day, they may be very different or abnormal at night while you sleep.

How can I sleep with all these things attached to me?

We try our very best to make your experience as comfortable and pleasant as possible. But we know it's not home, and that's okay. We do not expect (nor do we require) a 'perfect' night of sleep. For the vast majority of patients, we are able to get enough sleep data to make an accurate diagnosis.

Can I sleep in my usual position and can I turn over?

All the electrodes/sensors are attached so that they do not come off during sleep. You should be able to sleep as you do at home and turn over as usual. If you feel that you cannot sleep normally because of the electrodes, please call the sleep technologist to help you.

Will you give me any medication to help me sleep?

No. Our sleep center does not carry or dispense sleep aid medications. However, you are free to take any sleep aid medication you usually take at home. Just remember to bring it on the night of your sleep study.

What happens if I need to go to the bathroom during the night?

No problem. All the electrodes and sensors are plugged into a portable box. If you need to go to the bathroom, please notify the sleep technologist through the intercom. They will simply unplug the box to allow you to go to the bathroom.

Will anyone else be in the sleep laboratory when I am there?

A sleep technologist will be in a nearby control room the entire night. They are there to help you with everything and to make sure everything goes well.

When can I leave?

Usually the sleep technologist will wake you up between 5:00 and 5:30 AM. If you need to be up earlier, please let the sleep technologist know. They will remove all the electrodes and sensors. There will be a short questionnaire to fill out. Then you are free to leave!

What is a Multiple Sleep Latency Test?

Some patients are scheduled to stay the next day for what is called a Multiple Sleep Latency Test. This test evaluates you for excessive daytime sleepiness. When you wake up in the morning from your sleep study, the technologist will remove some of the electrodes and sensors.

At 2-hour intervals beginning at 8:00 AM, you will be asked to lie down in bed and close your eyes for twenty minutes to sleep. There are a total of 5 nap tests (8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM). When each nap is over, you will be asked questions about your sleep and how you feel. Between each nap test, you may watch TV, read, do some work, use your phone/tablet, etc.

How and when do I get the results?

All sleep studies contain an incredible amount of physiologic data which must be analyzed and reviewed. This is a time consuming process which we take very seriously. Some other places may advertise a quick turnover time.

At the *Sleep Diagnostic & Treatment Center,* we feel that a high quality and accurate analysis of your sleep study is of utmost importance.

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A DIVISION OF THE NEUROLOGY CENTER OF FAIRFAX, LTD.

Within 7-10 days of completing your sleep study, a staff member will call you by phone to provide you with the results of your sleep study. You are welcome to obtain a copy of your sleep study report anytime.

If your sleep study shows sleep apnea, you will be referred to do a "treatment" sleep study with CPAP therapy. After completing this study, you will be notified of the results within 7-10 days and be given the option to receive new CPAP equipment at home to treat your sleep apnea. In all cases, please make sure to schedule a follow-up visit with your physician.

We look forward to seeing you for your sleep study.

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AMERICAN ACADEMY OF SLEEP MEDICINE ACCREDITED MEMBER CENTER

SLEEP CENTER LOCATION	**For appointments**:	**PLEASE FAX THIS SIGNED FORM TO (571) 308-1158 IN ORDER TO SCHEDULE YOUR SLEEP STUDY. THANK YOU.**
3020 Hamaker Court **Suite 401** **Fairfax, VA 22031**	(703) 876-2850 **For after-hour emergencies** (703) 876-5645	

SLEEP STUDY GUIDELINES

1. **INSURANCE APPROVAL:** Please sign and fax this form to (571)-308-1158. Once this form has been received, we will work to obtain approval from your insurance company. This process can take up to 4-6 weeks. Once we have received authorization from your insurance company, we will call you to schedule your sleep study. ***In some cases, your insurance company may only authorize a home sleep study***, we will let you know

2. **SLEEP FORMS:** Please complete all the forms in the sleep packet and bring them with you on the night of your sleep study.

3. **ARRIVAL/DEPARTURE**: ***Please arrive at the sleep laboratory at 8:30 p.m. and not before***. Please arrange to leave by 5:30 a.m. the next morning. You will need to press the after-hours Neurology Center buzzer at the main doors to the building on Hamaker Court to obtain entry for your study.

4. **ROOM**: A private bedroom with bathroom (no shower) and television will be reserved for you. Please let us know as early as possible if you must cancel or reschedule your sleep study.

5. **WHAT TO BRING**: ***If you wear a hearing aid, please bring that with you. Bring your own pillow, toiletries, loose, comfortable clothing to sleep in***. If you will be staying for the daytime nap test (Multiple Sleep Latency test), you may want to bring reading materials and/or your computer to help pass the time between the nap tests. Please also bring something to eat for breakfast and lunch.

6. **BEFORE THE TEST**: Please take a shower before coming to the sleep center. To help us obtain the most accurate study, please do not put any type of gel, mousse, or spray into your hair. Also, please do not use any skin lotion, cream, or makeup.

7. **MEALS**: Please eat your normal dinner before coming to the sleep center. You will be finished with your sleep study prior to your breakfast time. Food and beverages are not kept in the sleep center.

8. **NAPS**: Try not to take any naps during the day before your test. We want you to be sleepy on the night of your sleep study.

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9. **ALCOHOL/CAFFEINE**: Please refrain from all the caffeinated and alcoholic beverages after 3:00 PM on the day of your sleep study.

10. **MEDICATIONS**: Please bring any medications you usually take at night and in the morning.

11. **COLDS AND FLU:** If you become sick before your sleep study, please reschedule the sleep study so that an accurate test can be performed. Please call us as soon as possible to reschedule your test.

12. **REGULATION**: Smoking, alcohol use, illegal substances, or weapons of any type are strictly prohibited on the premises.

13. **CANCELLATION**: Please provide at least **72-hours' notice** if you need to cancel your sleep study. A **$300** fee will be charged if you cancel within the **72-hours** or do not show up for your sleep study.

14. **FOLLOW-UP**: Within 7-10 days of completing your sleep study, a staff member will call you by phone to provide you with results of your sleep study. You are welcome to obtain a copy of your sleep study report any time.

    If your sleep study shows sleep apnea, you will be referred to do a "treatment" sleep study with CPAP therapy. After completing this study, you will be notified of the results within 7-10 days and be given the option to receive new CPAP equipment at home to treat your sleep apnea. In all cases please make sure to schedule a follow-up visit with your physician. You may also make an appointment to see our sleep specialist, Dr. Richard Cho.

    For more information about sleep apnea and CPAP therapy, please look in your packet or go to our website: http://yoursleepcenter.net

I UNDERSTAND THE ABOVE AND HAVE RECEIVED A COPY OF THIS FORM.

_____ _____

PRINTED NAME **DATE OF BIRTH**

_____ _____

PATIENT SIGNATURE **DATE**

Primary Phone Number: _____

Secondary Phone Number: _____

Sleep Study Information

Neurology Center of Fairfax

1) Your NCF physician may order a diagnostic sleep study (polysomnogram) to determine if you have a sleep disorder.

2) Our billing department will work to obtain insurance approval for your diagnostic sleep study and then will contact you to schedule the study.

3) The diagnostic sleep study will be performed at the Neurology Center of Fairfax (Suite 401).

4) If your diagnostic sleep study (polysomnogram) is normal, you will receive a letter in the mail. Please follow up with your NCF physician for further care and management.

5) If your diagnostic sleep study shows sleep apnea, you will be contacted and a second sleep study for CPAP (continuous positive airway pressure) titration will be ordered. This study will determine the best pressure setting and mask fit to treat your sleep apnea.

Our billing department will work to obtain insurance approval for your CPAP titration study and then will contact you to schedule the study.

6) After completing the CPAP titration study, Dr. Richard Cho (board-certified sleep specialist) will provide an order so that you can receive the appropriate CPAP (Continuous Positive Airway Pressure) equipment (machine, mask, tubing, etc.).

With your permission, the Neurology Center of Fairfax will submit your CPAP or other order and information to a reputable durable medical equipment company (DME). This company will provide you with the CPAP equipment. **PLEASE VERIFY THAT YOU HAVE THE PROPER PREAUTHORIZATIONS FROM YOUR INSURANCE COMPANY AND THAT THE DME COMPANY IS COVERED BY <u>YOUR</u> INSURANCE PLAN**.

7) You may return to see your NCF physician before starting CPAP therapy to ask questions about your diagnosis, sleep study results, and CPAP equipment. This is only if you desire to do so.

You also have the option to schedule a sleep-medicine consultation with Dr. Richard Cho, our board-certified sleep specialist. This is suggested by your neurologist.

8) As a patient using CPAP therapy, you must follow up with your physician or Dr. Cho on a regular basis in order to maintain insurance coverage of your CPAP equipment.

Medicare patients must have a face to face visit with their physician with documented sleep issues/symptoms within 6 months of the order for CPAP equipment.

MEDICARE PATIENTS must be seen by a physician between 31 and 90 days after initiation of CPAP therapy. The home CPAP data report must show the use of CPAP $\geq$ 4 hours per night on 70% of nights during a consecutive thirty-day period anytime during the first 3 months of initial usage. There also needs to be written documentation in the note that the patient is **"using and benefitting from CPAP therapy"** (exact wording).

Questions about sleep studies should be directed to the Sleep Center at 703-876-0800 ext. 5043. Leave a message and your call will be returned.

Questions about sleep equipment (i.e. CPAP machines, mask) should be directed to the Nurse Sleep Coordinator at 703-876-0800 ext. 1064. Leave a message and your call will be returned.

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Sleep Health Questionnaire

Name: _____ D.O.B.: _____ Date: _____

Present Height: _____ft _____in Present Weight: _____lbs

Please state in your own words the reason for a sleep evaluation.

_____

Have you had previous sleep evaluation? If so, when and what were the results?

_____

Please check any of the following that may affect your sleep

___ Snoring
___ Choking sensation
___ Shortness of breath

___ Morning dry mouth
___ Morning headache
___ Heart racing

___ Chest pain
___ Sweating at night

___ Difficulty falling asleep
___ Many awakenings

___ Worried about not sleeping
___ Anxiety/racing thoughts

___ Waking up before alarm
___ Sleep better when away from home

___ Urge to move legs
___ Relief with movement
___ Creepy crawley feeling

___ Leg/foot cramps
___ Pain or discomfort

___ Muscle tension
___ Symptoms worse at night

___ Nightmares/ bad dreams
___ Wake up in a panic
___ Wake up screaming
___ Wake up with violence

___ Wake up confused
___ Acting out in dreams
___ Sleep walking
___ Sleep talking

___ Eating at night
___ Wet the bed
___ Shaking/convulsive movements
___ Tongue biting

___ Feeling unable to move

___ Daytime sleep attacks

___ Sounds/images when falling asleep or waking up

___ Does your body become weak or limp with strong emotions

___ Noise
___ Caring for Children

___ Room temperature
___ Other (please describe): _____

___ Bed partner/moving

Have you had a motor vehicle crash (or near-miss) due to daytime sleepiness? If so, how often and/or when did it occur?

_____

_____

_____

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Name: _____ D.O.B.: _____ Date: _____

How much weight have you gained or lost in the past 1 year?
_____lbs

How often do you exercise? _____ times/week

What time of day? _____

Activities you do in the bedroom

How long per day and night?

Watch TV _____
Use a computer _____
Use a phone or tablet _____
Read _____
Work or study _____
Eat _____

Sleep Schedule

What time do you go to bed? _____
Do you take any sleep aids? _____
How long does it take you to fall asleep? _____
How many times do you wake up during the night? _____
What time do you wake up in the mornings? _____
How often do you take naps? _____
What are your work hours? _____
What days do you work? _____

Habits

How long per day and night?

Do you drink caffeinated coffee? _____
Do you drink caffeinated tea? _____
Do you drink caffeinated soda? _____
What time is your last drink? _____
Do you drink wine? _____
Do you drink beer? _____
Do you drink mixed drinks? _____
What time is your last drink? _____
Do you smoke cigarettes? _____
Do you smoke cigars? Do you chew tobacco? _____
What time is your last tobacco use? _____
How long have you use tobacco? _____

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Name: _____ D.O.B.: _____ Date: _____

Do you have a history of non-prescription drug use? If so, please list what you have used:

_____

_____

Likelihood of falling asleep	**0**	**1**	**2**	**3**
	0 = would never doze off	**1 = slight chance**	**2 = moderate chance**	**3 = high chance**
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting quietly in a public place (i.e. theatre or meeting)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when able to	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes	○	○	○	○

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Name: _____ D.O.B.: _____ Date: _____

Feelings Survey

1.
- I do not feel sad.
- I feel sad much of the time.
- I am sad all of the time.
- I am so sad or unhappy that I cannot stand it.

2.
- I am not discouraged about my future.
- I feel more discouraged about my future than I used to be.
- I do not expect things to work out for me.
- I feel my future is hopeless and will only get worse.

3.
- I do not feel like a failure.
- I have failed more than I should have.
- As I look back, I see a lot of failures.
- I feel I am a total failure as a person.

4.
- I get as much pleasure as I ever did from the things I enjoy.
- I don't enjoy things as much as I used to.
- I get very little pleasure from the things I used to enjoy.
- I can't get any pleasure from the things I used to enjoy.

5.
- I don't feel particularly guilty.
- I feel guilty over many things I have done or should have done.
- I feel quite guilty most of the time.
- I feel guilty all of the time.

6.
- I don't feel I am being punished.
- I feel I may be punished.
- I expect to be punished.
- I feel I am being punished.

7.
- I feel the same about myself as ever.
- I have lost confidence in myself.
- I am disappointed in myself.
- I dislike myself.

8.
- I don't criticize or blame myself more than usual.
- I am more critical of myself than I used to be.
- I criticize myself for all of my faults.

9.
- I don't have any thoughts of killing myself.
- I have thoughts of killing myself, but I would not carry them out.
- I would like to kill myself.
- I would kill myself if I had the chance.

10.
- I don't cry anymore than I used to.
- I cry more than I used to.
- I cry over every little thing.
- I feel like crying, but I can't.

11.
- I am no more restless or wound up than usual.
- I feel more restless or wound up than usual.
- I am so restless or agitated that I have to keep moving or doing something.

12.
- I have not lost interest in other people or activities.
- I am less interested in other people or things than before.
- I have lost most of my interest in other people or things.
- It's hard to get interested in anything.

13.
- I make decisions about as well as ever.
- I find it more difficult to make decisions than usual.
- I have much greater difficulty in making decisions than I used to.
- I have trouble making decisions.

14.
- I do not feel I am worthless.
- I don't consider myself as worthwhile and useful as I used to.
- I feel more worthless as compared to other people.
- I feel utterly useless.

15.
- I have as much energy as ever.
- I have less energy than I used to have.
- I don't have enough energy to do very much.
- I don't have enough energy to do anything.

16.
- I have not experienced any change in my sleeping pattern.
- I sleep somewhat more than usual.
- I sleep somewhat less than usual.
- I sleep a lot more than usual.
- I sleep a lot less than usual.
- I sleep most of the day.
- I wake up 1-2 hours early and can't get back to sleep.

17.
- I am no more irritable than usual.
- I am more irritable than usual.
- I am much more irritable than usual.
- I am irritable all the time.

18.
- I have not experienced any change in my appetite.
- My appetite is somewhat less than usual.
- My appetite is somewhat greater than usual.
- My appetite is much less than usual.
- My appetite is much greater than usual.
- I have no appetite at all.
- I crave food all the time.

19.
- I can concentrate as well as ever.
- I can't concentrate as well as usual.
- It's very hard to keep my mind on anything for very long.
- I find I can't concentrate on anything.

20.
- I am no more tired or fatigued than usual.
- I get more tired of fatigued more easily than usual.
- I am too tired or fatigued more easily than usual.
- I am too tired or fatigued to do most of the things I used to.

21.
- I have not noticed any recent change in my interest in sex.
- I am less interested in sex than I used to be.
- I am much less interested in sex now.
- I have lost interest in sex completely.

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PERMISSION TO PHOTOGRAPH AND/OR RECORD AUDIO AND VIDEO

I,_____,
Patient/Guardian

hereby authorize The Neurology Center of Fairfax/ Sleep Diagnostic and Treatment Center, or their representative, to take photograph(s) and/or record audio and video

of_____.
Name of Patient

I understand that such photograph(s), audio recording(s) and/or video recordings may be used for clinical or educational purposes, or in the event of legal action. The sleep center and directors of The Neurology Center of Fairfax, Ltd. and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings.

The undersigned also hereby transfers and assigns to The Neurology Center of Fairfax/ Sleep Diagnostic and Treatment Center the right to copy the materials in whole or in part. No use of the material for educational purposes will identify me by name.

_____ Check here if you do NOT authorize use for educational purpose

_____
Signature (patient or guardian) Date

_____
Relationship to Patient if Guardian

_____
Witness Date

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Medication list

Name: _____ D.O.B.:_____ Date: _____

Mail order pharmacies

Name	Address	Phone	Fax
_____	_____	_____	_____
_____	_____	_____	_____

Local pharmacies

Name	Address	Phone	Fax
_____	_____	_____	_____
_____	_____	_____	_____

Prescriptions

If you need additional space, continue on the next page

Name	Dosage	Frequency	Reason for Taking	Prescribed by
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Vitamins

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____

Over the counter medications

Name	Dosage	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Name	Severity
_____	_____
_____	_____

Additional Medications/Vitamins/OTC:

Name	Dosage	Frequency	Reason for Taking	Prescribed by

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MASK CLEANING INSTRUCTIONS

The Sleep Diagnostic & Treatment Center encourages patients to bring their own masks for use during their CPAP sleep study.

For hygienic and safety purposes, the below instructions must be followed on the day of your sleep study. These steps must be followed even if you use an automated CPAP machine cleaner.

1. The CPAP mask should be thoroughly washed at home with mild soapy water. The mask and straps should be washed on the inside and outside surfaces.
2. The mask should then be rinsed and air dried.
3. The mask should be stored in a clean paper bag and brought to the sleep center in the paper bag.
4. Upon arrival to the sleep center, the sleep technician will wipe the mask with a nontoxic disinfectant which is 99.9% germicidal.
5. Upon completion of your sleep study, the mask will be replaced in the paper bag for transport home.
6. Thank you for your cooperation.

SleepDiagnosticandTreatmentCenter.com
T 703.876.2850
3020 Hamaker Court
Suite 400 | Fairfax, VA 22031
A division of the Neurology Center of Fairfax, Ltd.

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CONSENT FOR POLYSOMNOGRAM

DETAILS

A polysomnogram is an overnight sleep study. It records detailed information that shows how your body acts while you sleep. A technologist will attach sensors to your body for the study. These sensors will monitor and record multiple body functions which include:

- Brain wave activity
- Heart rate and rhythm
- Breathing patterns
- Oxygen level
- Eye movements
- Chin movement

The study also may involve other sensors. These sensors send signals to a computer. The sleep center will use this information to prepare a detailed report about your sleep. The doctor who sent you to the sleep center will receive a copy of this report. He or she will then discuss the results with you. Please allow 14 business days for your doctor to receive your sleep report.

RISKS

You will sleep in the Sleep Laboratory as you would at home or in a hotel room.

AGREEMENT

My signature below indicates that I understand and agree with the following statements:

1. This sleep study may not detect the cause of my sleep problem.
2. A technologist will attach sensors to my body for the study.
3. These sensors may smell bad when they are placed on me.
4. The removal of the sensors in the morning may irritate my skin and cause redness.
5. A video camera will record me as I sleep. A technologist will watch me on a monitor in the control room.
6. I will be free to roll over and move in bed during the study.
7. I will need to ask for help if I must get out of bed for any reason.
8. The technologist may need to enter the room and wake me if there is a problem.
9. The study may show that I stop breathing many times during the night. If this happens, a technologist may enter my room to start treatment. This treatment is called positive airway pressure, or PAP. To use this treatment, I will need to wear a mask which covers my nose and possibly my mouth.
10. I understand why I am taking this sleep study.
11. I have discussed the need for the sleep study with my referring doctor.
12. The sleep center staff has explained the sleep study to me. I understand what is going to happen during the study.

All of my questions have been asked and satisfactorily answered. I agree to the performance of a sleep study with video recording.

_____

Signature (Patient or Guardian) **Date**

_____

Signature (Witness) **Date**

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COMMON QUESTIONS AND ANSWERS ABOUT SLEEP APNEA

What is sleep apnea?

Sleep apnea is a common and serious sleep disorder that causes a person to stop breathing while asleep. This causes stress and reduced oxygenation to the heart, brain and vital organs of the body. Sleep apnea often makes a person feel tired and unrefreshed in the morning. Daytime fatigue, brain fog, irritability and unintentionally falling asleep are other symptoms.

What are the symptoms of sleep apnea?

- Loud or frequent snoring
- Silent pauses in breathing
- Choking or gasping sounds
- Daytime sleepiness or fatigue
- Unrefreshing sleep
- Insomnia
- Morning headaches
- Nocturia (waking during the night to go to the bathroom)
- Difficulty concentrating
- Memory loss
- Decreased sexual desire
- Irritability

What are the risk factors for sleep apnea?

The major risk factor for sleep apnea is excess body weight. You are much more likely to have sleep apnea if you are overweight or obese/ However sleep apnea can occur in slim people too. Common risk factors for sleep apnea include:

- **Excess weight.** Your risk for sleep apnea is higher if you are overweight with a body mass index (BMI) of 25 or more or obese with a BMI of 30 or higher.
- **Large neck size.** Your risk for sleep apnea is higher if you have a neck size of 17 inches or more for men, or 16 inches or more for women. A large neck has more soft tissue that can block your airway during sleep.

- **Middle age.** Sleep apnea can occur at any age. However, it is more common as a person gets older.
- **Male gender.** Sleep apnea is more common in men than in women. For women the risk of sleep apnea increases with menopause.
- **Hypertension.** High blood pressure is extremely common in people who have sleep apnea.
- **Family history.** Sleep apnea is a heritable condition. This means that you have a higher risk of sleep apnea if a family member also has it. Inherited traits that increase the risk for sleep apnea include obesity and physical features such as recessed jaw. Other common family factors such as physical activity and eating habits may also play a role.

What are the consequences sleep apnea untreated?

- High blood pressure
- Heart disease
- Stroke
- Pre-diabetes and diabetes
- Depression

Untreated sleep apnea has also been associated dementia and cancer.

What treatment is there for sleep apnea?

- ***CPAP (Continuous Positive Airway Pressure)***
  CPAP is a machine that uses a steady stream of air to gently keep your airway open throughout the night so you are able to breathe. You sleep with a mask with a hose that is attached to a machine kept at the bedside. Masks and machines vary depending on your treatment and comfort needs. CPAP is the first line treatment for obstructive sleep apnea.
- ***Oral Appliance Therapy***
  An oral appliance is a device that fits in your mouth while you sleep. It may resemble a sports mouth guard or an orthodontic retainer. The device prevents the airway from collapsing by holding the tongue in position or by sliding your jaw forward so that you can breathe while you sleep. A dentist trained in dental sleep medicine can fit you with an oral appliance after you are diagnosed with sleep apnea. Oral appliance therapy is recommended for patients with mild to moderate apnea who cannot tolerate CPAP.

- ***Weight Management***
  In some cases weight loss can help improve or eliminate your sleep apnea symptoms if you are overweight or obese. Overweight people often have thick necks with extra tissue in the throat that may block the airway. There is no guarantee that losing weight will eliminate your sleep apnea, though it may help. This approach is less likely to make a difference in patients with narrow nasal passages or airway.

- ***Positional Therapy***
  This is a behavioral strategy to treat positional sleep apnea. For some people, sleep apnea occurs primarily when sleeping on their back. Their breathing returns to normal when sleeping on their side. Positional therapy may involve wearing a special device around your waist or back to keep you in the side position while asleep.

- ***Lifestyle Changes***
  There are a variety of lifestyle changes that you can make to help you reduce your snoring and improve your sleep apnea symptoms. Quitting smoking and not drinking alcohol may improve sleep apnea symptoms. Treatment of allergy symptom can also improve airflow through your nose. In all cases, please speak to your sleep doctor about how to best treat your sleep apnea.

Sleep
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COMMON QUESTIONS AND ANSWERS ABOUT CPAP

What is CPAP?
Continuous positive airway pressure (CPAP) therapy is the first line treatment for obstructive sleep apnea. CPAP therapy keeps your airway open during the night and providing a stream of filtered air through a mask you wear while you sleep. This allows you to breathe normally throughout the night and allows your body to receive the oxygen it needs.

What are the benefits of CPAP?
When you use CPAP each night, you will fell more alert during the day. Your mood will improve and you will have a better memory. CPAP prevents or even reverses serious health problems linked to sleep apnea such as heart disease and stroke. Your partner may also sleep better because you will stop snoring.

What is CPAP equipment?
CPAP comes with a machine, flexible tubing, and a mask. Most machines are small – about the size of a tissue box – lightweight and relatively quiet. The tubing connects the CPAP machine to your mask. The tubing is long enough to allow you to move around or turn over in your bed.

The CPAP mask may cover only your nose or both your nose and mouth. Another option is to use "nasal pillows" which fit in your nostrils. Whichever mask you use, it is important that it fits well and is comfortable. The mask must make a seal in order to keep your airway open through the night. A good mask seal will prevent air leaks and maintain the right level of air pressure.

You can keep the CPAP machine on your nightstand or at the side of your bed. Today's CPAP machine are portable and easy to travel with.

What will be my CPAP setting?
Your sleep doctor will determine the right amount of air pressure needed for CPAP to treat your sleep apnea. Often, a sleep study with CPAP titration is required to determine your correct air pressure setting. All CPAP machines come with a timed pressure "ramp" setting. This starts with airflow at a very low level so that you can fall asleep comfortably. The pressure slowly rises while you sleep until it reaches the right level to treat your sleep apnea.

How do I get a CPAP machine?
Your sleep doctor can prescribe all of your CPAP equipment. This is done through an equipment company contracted with your insurance company.

All insurance companies recognize sleep apnea has a serious health condition. Reimbursement for the CPAP equipment will vary by each insurance company and plan. We suggest you contact your insurance company and inquire about your durable medical equipment benefits.

NEUROLOGY CENTER OF FAIRFAX, LTD.

Fairfax Office 3020 Hamaker Ct, Suite 400, Fairfax, VA 22031
Reston Office 1830 Town Center Dr, Suite 305, Reston, VA 20190
Office Phone 703.876.0800 | Fax 703.876.0866
After hours emergency 703.755.1450

When You Need Copies of Medical Records…

NCF is very sensitive to patient needs for copies of their medical records. The State of Virginia regulates the response times and fees to patients for copying records. The federal government regulates privacy concerns involved in copying.

NCF has contracted with Sharecare HDS to service medical records requests. We do not copy records in our office. If you need copies of medical records, please follow these steps.

1. Authorization form: The law requires patients to authorize copying in writing by specifying what is to be sent and the recipient. Your authorization is good for one year.

Please complete the authorization form provided with this information sheet. By law you may not request copies of the records of another adult, even a family member, unless you have a proper medical power of attorney. We accept faxed authorization forms at 703-876-0258.
Blank forms are available at www.neurologycenteroffairfax.com

Please specify the records you need, based on the choices on the authorization. If you are sending records to another doctor, Sharecare HDS already knows what to send.

2. Costs: Virginia law defines fees that are charged to you, based on the number of pages to be copied. **You pay these costs in advance directly to Sharecare HDS.** There are multiple ways to pay these charges, as noted on the invoice you receive from Sharecare HDS. Copying fees apply in all cases except the following: (1) if an NCF physician refers you to another doctor and (2) if another doctor sends a proper request that you have authorized. (The last two office visits and the most recent test results will be sent at no charge.) Fees apply to all requests for full copies of records.

Please remember that copying fees are payable to Sharecare HDS in advance. Sharecare HDS will send you an invoice. (You can also speed up the process by prepaying your fees with a credit card when you call 877-270-4365. The best day to call customer service is the Friday or Monday following your request.)

Medical record copying fees are defined in Code of VA. §8.01-413. Call Sharecare HDS for further information.

3. Response Times: Virginia law provides 30 days to respond to copying requests, with a 30 day extension if justified. Most requests are fulfilled in less time, once the fees are paid. Please do not expect the copying to be done while you wait, except in a medical emergency. Longer response times occur when the records you request are in long term storage.

4. Service: Call Sharecare HDS customer care at 877-270-4365 if you have any questions or problems.

NEUROLOGY CENTER OF FAIRFAX, LTD.

Authorization to Disclose Protected Health Information
The undersigned authorizes Neurology Center of Fairfax, LTD.
3020 Hamaker Court, Suite 400, Fairfax, VA, 22031
(P) (703) 876-0800 ext. 5004 (F) (703) 876-0258
to release my health information as noted below:

Patient Information

Patient Full Name: _____ **Other Names?** _____

Patient Address: _____ Date of Birth: _____

City:_____ State: _____ Zip: _____ Phone #: _____

Release Information To

Email address for record delivery: *Please ensure email address is legible!*

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email or mail.

Name/Facility:_____ **Attention:** _____

Address:_____ Phone:_____

City: _____ State:_____ Zip: _____ Fax #:_____

Purpose of Request: Personal ____ Treatment ____ Legal ____ Insurance ____ Transfer ____ Other:____

Information to be Released

If you fail to specify, a 1-year abstract will be provided.

___Please release a **1-year abstract** of my records (includes most recent notes, labs, procedures & testing)

___Please release a **2-year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

___**Date Range**:_____:

□ Progress Notes □ Radiology Reports □ Labs
□ Operative Reports □ Injections □ Physical Therapy
□ Other: _____

___**Radiology Disc**

(**Please pick ONE delivery option**)

[ ] Send by Email [ ] Records on CD	**[ ] Fax to Doctor**	**[ ] Records on Paper**

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed VA Statute: §8.01-413

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____(*Please Initial)*

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____ *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety – if form is incomplete, or protected information is not released, we may be unable to fulfill this request.

Signature*: _____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy -of the legal documentation for patient's representative must be supplied with a copy of this form.*