



Barry L. Katchinoff, M.D.

*Diplomate of the American Academy of Neurology
Diplomate of the American Board of Sleep Medicine*

Dear _____:

We look forward to seeing you on _____, _____ at _____ AM/PM

You have been scheduled for the following:

- **PSG** (Polysomnogram) This involves an overnight stay in a private room. Each room has a half bathroom and cable television. You will be monitored with several skin sensors that record brain waves, heart rate, eye movements, leg movements, and breathing. All sensors are attached on you skin and are painless.
- **VIDEO** – At any point in the time of testing we feel your sleep activity needs to be recorded, we will record you on video. You will be expected to sign a consent form to give us permission to do so.
- **PAP** (Positive Airway Pressure) –This therapeutic device is used to treat sleep apnea. The same skin sensors used with a Polysomnogram will record your sleep, along with a mask you wear over your nose or nose/mouth, which is attached to the PAP machine. Further education on sleep apnea and PAP will be provided by the sleep technician. You may not receive this procedure if the following was not attained during the sleep study:
 - Insufficient or no sleep data
 - No evidence of sleep apnea, mild to moderate sleep apnea attained past mid-study
 - Specific order from the referring physician or sleep physician
- The sleep study will end approximately 6 am in the morning.

Prior to your scheduled testing date, please let us know if you are claustrophobic or have chronic nasal problems.

THE DAY OF YOUR TEST

1. Do not drink alcohol.
2. Do not drink caffeine.
3. Do not take any naps.
4. Try to maintain your regular daytime routine.
5. Take your normal maintenance medication as prescribed unless specifically stated by your physician or specialist.
6. The following products should be removed to ensure quality sleep recording:
 - Facial Makeup
 - Body lotion
 - Hair products -i.e. hair spray, hair gel, mousse
 - Corn Rows or Weaves (Techs must be able to get to the scalp, wigs may be worn to the study)
 - Fingernail Polish

WHAT TO BRING

1. Please complete the enclosed **medical questionnaire, insurance card, ID card or driver's license, patient information sheet and type of payment for co-pays.**
2. If you take maintenance medicine, you must bring your own medication with you. This is an outpatient test so you will have to administer your medication yourself (including insulin).
3. Please be sure to bring 2 piece pajamas, toothbrush, and your own pillow if you prefer.
4. You may want to bring along reading material.
5. You may bring a small snack and decaffeinated beverages.

GENERAL INFORMATION

YOU MUST CALL TO CONFIRM YOUR APPOINTMENT AT LEAST 48 HRS PRIOR TO YOUR APPOINTMENT

1. Please verify that your **insurance coverage is current.**
2. If you have an insurance that requires **a referral or an authorization number** please call your Primary Care Physician and/or you're referring MD to initiate it and have it forwarded to **Sleep Diagnostics**. You will be asked to sign a "Waiver of Insurance" if the referral is not available; or reschedule your appointment.
3. A Specialists co-pay or % deductible may vary per your insurance plan.
4. This is a **NO SMOKING** facility.
5. If you have an illness, please contact our center to reschedule your appointment. Please give us approximately **24-48 hours** prior to the scheduled appointment to avoid late cancellation or reschedule charges. ***SEE OFFICE POLICY***
6. If you have a spouse or person driving you from out of town, he/she may need to make arrangements at a local hotel/motel.

If you have any questions, please call us at (804) 272-6896.

Sincerely,

Office Staff