Trinity Health

Trinity Health Livingston
Sleep Disorders Center
620 Byron Road
Howell, MI 48843
Office: 517-545-6690
Fax: 517-545-6692

PLUE Sticker

Return Visit Information

Dear _____,

Your CPAP Titration will begin the night of _____ at 8 p.m. and will end the following day between 6 a.m. and 7 a.m.

The Sleep Disorders Center is located on the campus of Trinity Health Livingston Hospital in Howell. Parking is available in front of the building. Enter the main building and take the elevators next to the pharmacy, up to the third floor, turn left down the hallway and the Sleep Disorders Center is at the end of the hall.

ARRIVAL TIME: If you are not able to arrive by 8 p.m. please call the lab at 517-545-6690 and inform a member of our staff. Late cancellations or missed appointments may be subject to a $200 fee. Please, if you are unable to keep your scheduled appointment, we require 48-hour notice.

SCHEDULING CHANGES: please call Central Scheduling at 734-712-1313, Option 2.

If you have any questions or special needs that the Sleep Disorders Center staff should be aware of such as hospital bed, please notify us prior to your test by calling 517-545-6690.

Prior to the Sleep Study

Carefully read the following Information:

REGISTRATION: You must register for your outpatient sleep test by calling 800-676-0437, Monday through Friday between the hours of 8 a.m. and 5 p.m. prior to the date of your test.

WHAT TO EXPECT DURING THE STUDY: The Sleep Disorders Center technician will apply electrode wires to your head, torso and legs. There is little, if any, discomfort involved. You will be sleeping approximately eight hours.

QUESTIONNAIRE: A questionnaire concerning your medical history and sleep habits are a part of this packet. Please fill it out as completely as possible and bring it with you the night of your test.

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Preparation Instructions

ALCOHOL: Avoid drinking any alcoholic beverages on the day of your test, unless you have been told to do so by your doctor.

CAFFEINE: Do not drink any coffee, tea or caffeinated beverages after 5 p.m. on the day of your test. You should not have any kind of caffeine (including chocolate) until your test is completed.

FLUIDS / NAPS: Do not drink large amounts of any fluids after 5 p.m. the day of your sleep test or take any naps the day of your test if you can possibly avoid it.

HYGIENE: Please wash your hair prior to coming in for your sleep test. Do not use hairspray, mousse or gel. Do not wear braids or hair extensions. Women should not wear nail polish, heavy makeup or skin creams. Men should shave, unless you have a beard. This will help us to attain the highest quality of test results.

MEALS / SNACKS: Breakfast and lunch trays will be provided for patients who stay throughout the day following their overnight study. Please, notify your technician if you have a special diet. You may also bring your own food or **snacks from home.**

MEDICATIONS: Your sleep test is an outpatient procedure, nursing services and medication will not be provided. If you take medication regularly, bring it with you and take it as usual.

SMOKING: The Sleep Disorders Center and the campus of Trinity Health Livingston is a smoke-free environment. Smoking is not permitted on the premises.

SLEEPWEAR: Please wear comfortable sleep clothing such as pajamas or shorts and t-shirt; please avoid fleece and silky material. If you have a favorite pillow or blanket, please bring it with you so you will feel more at home.

Thank you for Choosing
Trinity Health Livingston for your Sleep Study

Our Sleep Disorders Center is accredited through the American Academy of Sleep Medicine.

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Sleep Disorders Clinic Return Visit Questionnaire

Patient Name _____ Date _____

Address _____

Telephone: Day _____ Evening _____

Height _____ Weight _____

Have you had any treatment for your sleep disorders since your last visit to the clinic?

☐ Yes ☐ No If yes, please describe the treatment _____

_____

Since your last visit, have you changed the amount of caffeinated beverages (coffee, tea, cola, etc.) you drink on the average?

☐ Yes ☐ No If yes, please describe the treatment _____

_____

Since your last visit, have you changed the prescription drugs which you take?

☐ Yes ☐ No If yes, please describe the treatment _____

_____

Have your sleeping habits changed since your last visit?

☐ Yes ☐ No If yes, please describe the treatment _____

_____

Are there any changes which we should know about regarding your health and/or sleep since your last visit?

☐ Yes ☐ No If yes, please describe the treatment _____

_____

_____