Trinity Health Ann Arbor
Sleep Disorders Center
5301 East Huron River Drive
P.O. Box 995
Ann Arbor, Michigan 48106-0995
Office: 734-712-4651
Fax: 734-712-2967

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 Ann Arbor, 5305 Elliott Drive, Ypsilanti in the 5305 Building (Administration Services). Parking is available in lot P in front of the building. Enter the 5305 Building and take the elevator/stairs to the third floor, turn right and go into the Sleep Disorders Center. Check-in at the front window.

ARRIVAL TIME: If you are not able to arrive by 8 p.m. please call the lab at 734-712-2440 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 734-712-2440.

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 will also be able to go to the hospital Market Cafe. Snacks are available in the vending room in McAuley Inn. You may also bring your own food or **snacks from home. A refrigerator and microwave oven are available for your use.**

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 Ann Arbor 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 Ann Arbor for your Sleep Study

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

PLUE Sticker

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 ____________________

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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 ____________________

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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 ____________________

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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 ____________________

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