

McLAREN OAKLAND
SLEEP DIAGNOSTIC CENTER
STUDY SUMMARY

Date: ____ / ____ / ____ Room #: _____ Study Type: _____

Patient: _____ Tech Assigned: _____

Patient Questionnaire on chart: Yes No Explain: _____

Usual Bedtime: _____ a.m. / p.m. Usual Wake time: _____ a.m. / p.m. **Requested Wake Time:** _____ **a.m. / p.m.**

Sleep Study Began: _____ a.m. / p.m.

If > 30 minutes later than usual, please explain: _____

Please describe your observation of the patient and any pertinent information regarding the sleep study:

Sleep Onset Epoch #: _____ REM Onset Epoch #: _____

Respiratory Events: _____

Oxygen: Current Home O2: _____ lpm DME: _____ Baseline O2: _____

O2 Required during this study: _____ lpm Lowest O2 Desaturation: _____

PLMS: absent occasional frequent

EKG: normal sinus rhythm arrhythmias

Sleep Efficiency: _____ If poor, what were pt. complaints? _____

Mechanical problems or uncorrectable artifact: _____

CPAP/BI-LEVEL TITRATION

Final Pressure: _____ cm

Did final pressure appear adequate? Yes No Explain: _____

PT.

MR./P.M.

DR.