

Denton Sleep Disorders Laboratory

GENERAL PRE-SLEEP STUDY INFORMATION

You have been scheduled for an overnight sleep study, per your physician's order. The study will be performed at the sleep lab located at 3200 Colorado Blvd., Suite 200 in Denton. Your study has been scheduled for _____ night, _____ at _____ p.m. **If you need to cancel your sleep study for any reason, please notify our office no later than 24-hours prior to your study date. Failure to call our office within the allotted time will result in a cancellation charge of \$50.00.**

FOR SECURITY REASONS ONLY MONEY ORDERS, CHECK OR CREDIT CARDS WILL BE ACCEPTED FOR PAYMENTS NO CASH.

In order to get the best results from your overnight stay, please review the following recommendations:

1. Do not drink or eat anything containing caffeine the day of your study. This includes chocolate, caffeinated soft drinks, coffee or tea.
2. Try to wake up earlier the day of your study and do not take a nap the day of the study.
3. You will need to take a bath/shower shortly before coming in for your study in order to remove oils that accumulate during the day. Make sure to wash with soap and a washcloth in order to properly remove all oils. Do not put on lotion or after-bath powders after bathing. Please make sure that you have a clean shaved face before coming in for your study.
4. If you would like to bring your own pillow, you may. However, the sleep center will provide you with pillows.
5. Bring something comfortable to sleep in. If you don't usually wear pajamas, don't feel the need to buy them for the study. Loose fitting shorts and a tee shirt are acceptable. Your comfort is an essential part of the diagnostic test. You may want to bring a robe to wear before you actually go to bed.
6. You will generally be awakened between 5:30 a.m. and 6:00 a.m., unless otherwise requested.
7. There is a shower at our facility with essentials such as towels, washcloths, shampoo, conditioner and soap provided for your convenience.
8. You may bring reading material or anything that will help you pass the time if you have trouble falling asleep or have a bedtime that is a half hour or more later than the scheduled hook-up time of sleep equipment. There is also satellite television available if you prefer.
9. Please remember to bring any and all completed **Questionnaires** that have been sent to you. These materials are crucial for the analysis and interpretation of your sleep study. The technician will make sure all of the information in your packet is completely filled out. If not, we will not begin your study until all information is completed.
10. If you have any further questions not answered by this pre-sleep information guide, please feel free to contact our office and we will be happy to answer any remaining questions you may have.

Denton Sleep Disorders Laboratory

Patient Registration

Name _____ Height _____ Weight _____ SS# _____
Street Address _____ Date of Birth _____ Marital Status: S M W Sep D
City _____ State _____ Zip _____
Telephone Home _____ Telephone Office _____
Primary Care Physician _____ Referring Physician _____
Spouse's Name _____
Spouse's Employer / Address _____
Emergency Contact _____ Telephone _____ Relationship _____

Patient Employer Information

Employer Name _____ Telephone _____
Employer Street Address _____ City/State _____ Zip _____
Patients Occupation _____

Insured Person (If not patient)

Employer Name _____ Telephone _____
Employer Street Address _____ City/State _____ Zip _____
Relationship to Patient _____

Insurance

Medicaid # (if applicable) _____ Medicare # (if applicable) _____
Primary Insurance Company Name _____
ID # _____ Group # _____ Telephone _____
Secondary Insurance Company Name _____
ID # _____ Group # _____ Telephone _____

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize Dr. Mukesh Saraiya to apply for benefits on my behalf for covered services rendered by him or his order. I request that payment from my insurance company/companies be made directly to Dr. Mukesh Saraiya (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____
(Patient, parent, or guardian)

Denton Sleep Disorders Laboratory

Dear Patient,

If you test positive for sleep apnea, there will be equipment that will need to be ordered for you. If you have any preference for where your equipment is ordered, please list below.

- I have a company that I would like the order sent to the company listed below.

Company Name _____

Telephone _____

- I have no preference; please send the order to a company that is preferred by my insurance.

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Patient Sleep / History Questionnaire

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Thank you for your patience.

Patient Observation

In as much detail as possible, please describe the problem you are having.

Have you had a sleep problem diagnosed before? _____ Yes _____ No

If yes, when and where was your study performed? _____

If yes, what was the diagnosis? _____

If yes, what treatment(s) was/were recommended? _____

Are you currently on a CPAP/BIPAP? _____ Yes _____ No

If yes, what pressures? _____

Are you currently on home oxygen? _____ Yes _____ No

If yes, how often and when do you use it? _____

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Patient Sleep / History Questionnaire

General Information

How often does the problem you are experiencing occur?

Almost every night For periods of at least one week Irregularly
 Other: _____

How long has this problem bothered you?

Within the past month Within the past 6 months Within the past 12 months
 1-2 years 3-5 years Over 5 years Other: _____

On the scale below, please estimate the severity of your problem(s).

Not upsetting Mildly upsetting Moderately upsetting
 Very upsetting Extremely upsetting Totally incapacitating

How strongly do you want help with this problem?

Does not bother me Could do without it Would like to correct it
 Need to correct it Cannot continue with it

How do you describe your sleep problem? (Check all the apply)

I have difficulty falling asleep.
 I wake up repeatedly throughout the night
 I wake up far too early in the morning
 I feel excessively sleepy during the day
 I find it difficult to wake up in the morning

Has your environment changed recently? (moved, loss of family member, loss of job, new bed, divorce, etc.)

Yes No If yes, please explain: _____

Have you or anyone else noticed a change in your personality? Yes No

Do you have a high stress job? Yes No N/A

Is your job satisfactory? (Does your sleep problem require you to cut back on social activities?)

Yes No If yes, please describe: _____

Do you usually: (Check all that apply)

Sleep with someone else in bed Sleep with someone else in your room
 Provide assistance to someone during the night (child, invalid, partner, animal, etc.)

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Patient Sleep / History Questionnaire

Sleep Schedule and Noteworthy Events

Do you: Work Go to school I don't work or go to school Retired
Do you work/go to school: Always the same hours Rotating shifts N/A
Which shift(s) do you work/go to school? (Check all that apply): 1st 2nd 3rd
Do you maintain a regular and consistent sleep schedule: Yes No
How many hours of sleep do you average during work days? _____ During days off? _____
What time do you usually go to bed during work days? _____ During days off? _____
What time do you usually wake up during work days? _____ During days off? _____
How long does it usually take you to fall asleep? _____
Do you wake up at night? Yes No If yes, how many times? _____
Do you nap during the day? Yes No If yes, how often and how long? _____
Do you feel refreshed after naps? Yes No N/A
While in bed, I: Read Write Watch TV Eat Worry/have arguments

Symptom Information

Have you ever had a near miss accident due to falling asleep while driving? Yes No
Have you had an accident in the past year due to falling asleep while driving? Yes No
Have you been diagnosed by a physician as having hypertension? Yes No
Have you ever had your nose broken? Yes No
Do you still have your tonsils? Yes No
Are you experiencing any memory or learning problems? Yes No
Are you having difficulty at work or school due to excessive sleepiness? Yes No
When you wake up, are your bed covers extremely messy in the morning? Yes No
Do you awaken yourself by kicking your legs during the night? Yes No
Has a bed partner ever complained of your legs kicking during the night? Yes No
Excluding leg kicks, do you make other unusual movements during sleep? Yes No

Patient Family History

History of Obstructive Sleep Apnea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Father	Mother	Sibling
History of Insomnia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Father	Mother	Sibling
History of Narcolepsy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Father	Mother	Sibling
History of other sleep disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Father	Mother	Sibling

Denton Sleep Disorders Laboratory

Patient Sleep / History Questionnaire

Frequency Scale

Using the following scale, please rate how often these symptoms occur:

N = Never **R** = Rarely **O** = Occasionally **F** = Frequently **A** = Always

- | | |
|--|--|
| _____ I exercise | _____ I wake up with heartburn |
| _____ I sleep walk | _____ I wake up belching |
| _____ I wake up short of breath | _____ I feel sad and/or depressed |
| _____ I wake up gasping for air | _____ I worry all the time |
| _____ I wake up coughing | _____ Thoughts constantly race through my mind |
| _____ I wake up confused | _____ I am bothered by pain during the day |
| _____ I have trouble breathing while asleep | _____ I wake up at night due to pain |
| _____ I stop breathing while asleep | _____ I wake up with sore/achy muscles |
| _____ I get morning headaches | _____ I wake up feeling stiff |
| _____ I have frequent sinus congestion | _____ I wake up with neck, spine or back pain |
| _____ I wake up with a dry mouth or sore throat | _____ I have morning jaw pain |
| _____ I snore | _____ I grind my teeth at night |
| _____ I snore loudly enough to disturb others | _____ I fall asleep during emotional situations |
| _____ My sleep is restless | _____ I fall asleep during physical effort |
| _____ I fall asleep during the day | _____ I experience muscle weakness during emotional situation |
| _____ I notice irregular heart pounding at night | _____ I feel unable to move when waking or going to sleep |
| _____ I feel afraid to fall asleep | _____ I have vivid dream-like scenes when waking or going to sleep |
| _____ I remember my dreams | _____ I have vivid dream-like scenes when waking or going to sleep |
| _____ I have nightmares or night terrors | _____ I have muscular tension |
| _____ I notice parts of my body jerk | _____ I experience leg pain during the night |
| _____ I move excessively at night | |

Denton Sleep Disorders Laboratory

Patient Sleep / History Questionnaire

Self Worth Scale

I feel: (Check all that apply.)

- | | | | |
|--------------------------------------|---|---|--|
| <input type="checkbox"/> Attractive | <input type="checkbox"/> Unassertive | <input type="checkbox"/> Unloved | <input type="checkbox"/> Ugly |
| <input type="checkbox"/> Worthwhile | <input type="checkbox"/> Lonely | <input type="checkbox"/> Confused | <input type="checkbox"/> Naïve |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Restless | <input type="checkbox"/> Like a nobody | <input type="checkbox"/> Morally wrong |
| <input type="checkbox"/> Sympathetic | <input type="checkbox"/> Full of regret | <input type="checkbox"/> Incompetent | <input type="checkbox"/> Cowardly |
| <input type="checkbox"/> Considerate | <input type="checkbox"/> Overweight | <input type="checkbox"/> Full of hate | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Intelligent | <input type="checkbox"/> Useless | <input type="checkbox"/> Agitated | <input type="checkbox"/> Bored |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Stupid | <input type="checkbox"/> Aggressive | <input type="checkbox"/> In conflict |
| <input type="checkbox"/> Worthless | <input type="checkbox"/> Hostile | <input type="checkbox"/> Repulsive | <input type="checkbox"/> Unconfident |
| <input type="checkbox"/> Inadequate | <input type="checkbox"/> Evil | <input type="checkbox"/> Misunderstood | <input type="checkbox"/> Life is empty |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Panicky | <input type="checkbox"/> I can't do | <input type="checkbox"/> I often have |
| <input type="checkbox"/> Guilty | <input type="checkbox"/> Unattractive | <input type="checkbox"/> anything right | <input type="checkbox"/> horrible thoughts |

Self Worth Scale

Please check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> I often have morning headaches | <input type="checkbox"/> I often feel dizzy |
| <input type="checkbox"/> I often have heart palpitations | <input type="checkbox"/> I have frequent stomach problems |
| <input type="checkbox"/> I suffer from bowel disturbances | <input type="checkbox"/> I am constantly fatigued |
| <input type="checkbox"/> I have frequent nightmares | <input type="checkbox"/> I take sedatives |
| <input type="checkbox"/> I feel tense all of the time | <input type="checkbox"/> I have frequent panic attacks |
| <input type="checkbox"/> I am often depressed | <input type="checkbox"/> Sometimes I have suicidal ideas or thoughts |
| <input type="checkbox"/> I seem unable to relax | <input type="checkbox"/> I have problems with sex |
| <input type="checkbox"/> I don't like weekends or vacations | <input type="checkbox"/> I am over ambitious |
| <input type="checkbox"/> I can't seem to make friends | <input type="checkbox"/> I have problems remembering things |
| <input type="checkbox"/> I have overwhelming financial problems | <input type="checkbox"/> I suffer from fainting spells |
| <input type="checkbox"/> I can't seem to keep a job | <input type="checkbox"/> I feel I am inferior to others |
| <input type="checkbox"/> I have no appetite lately | <input type="checkbox"/> I suffer from insomnia |
| <input type="checkbox"/> I am an alcoholic | <input type="checkbox"/> I suffer from tremors |
| <input type="checkbox"/> I take drugs | <input type="checkbox"/> I am shy with people |
| <input type="checkbox"/> I can't seem to make decisions | <input type="checkbox"/> My situation at home is bad |
| <input type="checkbox"/> I am unable to have a good time | <input type="checkbox"/> I have difficulty concentrating |
| <input type="checkbox"/> I take antacids regularly (Tums, etc.) | <input type="checkbox"/> Other: _____ |

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Patient Sleep / History Questionnaire

Medical History and Information

Please list any surgeries/medical procedures that you have had performed in the past year.
(Please use other side of form if necessary.)

Procedure	Date	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any diagnosed medical conditions that you are currently receiving care from a physician.
(Please use other side of form if necessary.)

Medical Condition/Problem	Course of Treatment (Medicine, surgery, etc.)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any other health information that you feel is pertinent to your study or care.
(Please use other side of form if necessary.)

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Patient Sleep / History Questionnaire

Medication Information

Please list below any medications you have taken within the past 72 hours.
(Please use other side of form if necessary.)

Medication	Reason	Dose	Date	Time
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If applicable, please list below any medications you have taken within the past week to help you go to sleep or stay awake. (Please use other side of form if necessary.)

Medication	Reason	Dose	Date	Time
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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Epworth Scale

Patient Name _____ Date _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you have not done some of the things recently, try to work out how they would have affected you.

Use the following scale to enter the most appropriate number for each situation.

- | | |
|------------------------------------|--------------------------------------|
| 0 = Would never doze | 2 = Moderate chance of dozing |
| 1 = Slight chance of dozing | 3 = High chance of dozing |

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. theater).....	_____
As a passenger in a car for an hour without a break.....	_____
Lying down to rest in the afternoon when circumstances permit .	_____
Sitting and talking to someone.....	_____
Sitting quietly after a lunch without alcohol.....	_____
In a car, while stopped for a few minutes in traffic.....	_____
Total Score.....	_____

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**Please fill out the next
two pages the
day of your study.**

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Patient Bedtime Questionnaire

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Thank you.

Last Name _____ First _____ MI _____

Test Date _____ Technician _____

1. What time did you go to bed last night? _____ AM PM
2. What is your estimate of how long it takes you to fall asleep at night? _____ minutes
3. What time did you wake up this morning? _____ AM PM
4. What time did you actually get out of bed? _____ AM PM
5. Approximately how many times did you wake up last night? _____
6. On average, how long were you awake each time? _____ minutes hours
7. How long does the amount of sleep you got last night compare to an average night's sleep?
_____ less than average _____ about the same _____ more than average
8. Did you take any naps today? _____ Yes _____ No If yes, how many? _____
9. What was the average length of each nap? _____ minutes N/A
10. What time was your last nap? _____ AM PM N/A
11. What time did you last eat? _____ AM PM
12. Was this a snack or a meal? _____ Meal _____ Snack
13. Did you have any alcoholic beverages today? _____ Yes _____ No
If yes, what was the total number of ounces? _____ ounces
If yes, what time was your last drink? _____ AM PM

Denton Sleep Disorders Laboratory

Patient Bedtime Questionnaire

14. Did you drink any beverages containing caffeine today? _____ Yes _____ No
If yes, what was the total number of ounces? _____ ounces
If yes, what time was your last drink? _____ AM _____ PM

15. Choose the statement below that best describes the way that you feel right now.
_____ Feeling active and vital, wide awake
_____ Functioning at a high level, but not at peak; able to concentrate
_____ Relaxed and awake; not at full alertness; responsive
_____ A little groggy; not at peak; let down
_____ Groggy; starting to lose interest in staying awake; slowed down
_____ Almost in a daydream state; will fall asleep soon; lost the struggle to stay awake

16. Do you feel like going to bed now? _____ Yes _____ No

17. Do you have any physical complaints now? _____ Yes _____ No
If yes, please describe: _____

18. Did anything out of the ordinary happen to you today? _____ Yes _____ No
If yes, please describe: _____

19. Please make any additional comments that you feel are pertinent to your sleep problem/study.

Denton Sleep Disorders Laboratory

Sleep Hygiene – A Guide to a Better Night’s Sleep

What is “Sleep Hygiene”? In the same way that dental hygiene is observed to promote strong and healthy teeth, sleep hygiene should be observed to promote good and healthy sleep. Your habits while awake affect the way that you sleep in many ways. In order to promote the best possible sleep, these following steps should be observed.

1. **Keep Regular Hours.** The best way to ensure a good night of sleep is to stick to a regular schedule. To keep your biologic clock in “sync”, keep a regular bedtime and wake up at the same time, regardless of how much or how little you feel you’ve slept.
2. **Exercise Regularly.** Exercise helps by burning off tension, which allows you to “unwind” mentally and physically. The ideal time is late afternoon or early evening. However, exercise should be completed 4-6 hours before your bedtime.
3. **Reduce Stimulants.** People in the United States drink an average of 400 million cups of coffee daily and get extra caffeine in tea, cola, and chocolate. Have your last beverage containing caffeine at 6-8 hours before your bedtime. If you are taking any prescription or over-the-counter medications, ask your doctor whether they may affect your sleep.
4. **Sleep on a Good Bed.** If your bed is older than 8 years, consider obtaining a new one. Consider cervical supports or pillows if medical conditions warrant their use.
5. **Reduce or Stop Smoking.** The nicotine found in cigarettes is a stronger stimulant than caffeine. Studies have shown that smokers who break their habit have dramatic improvements in sleep.
6. **Don’t Drink Alcohol or Only Drink in Moderation.** Even moderate drinking can suppress REM sleep and deep sleep and result in fragmented, unrefreshing sleep. If you do drink alcohol, have it at least 4-6 hours before sleep.
7. **Get Quality Sleep, Not Just Quantity.** The normal range of total sleep at night is from 6-10 hours, depending on the individual. Maintaining a sleep diary, as directed by your sleep doctor, can determine how much sleep you really need to feel refreshed. Too much sleep can be bad as well.

Denton Sleep Disorders Laboratory

Sleep Hygiene – A Guide to a Better Night's Sleep

8. **Set Aside a “Worry Time”.** Try to resolve problems early in the evening, before going to bed. If distractions follow you to bed, tell yourself to deal with them during the next day's “worry time”. Psychological stress may result from job insecurity, deadlines and competency testing. Marital conflict may be another source of stress. Do not attempt to solve these or other stress problems just before going to bed. Look for ways to handle them during your “worry time” the next day.
9. **Don't Go To Bed Stuffed or Starved.** Avoid late night meals. Avoid snacks cause gas, such as peanuts, beans or raw vegetables. If you are dieting, don't go to bed hungry. Eat a low calorie snack, such as an apple or banana.
10. **Avoid Napping.** Don't take naps during the daytime, particularly if you have trouble falling asleep at night. Prolonged naps, especially 8-12 hours after awakening can disrupt your biologic sleep rhythm.
11. **Get a Sleep Ritual.** Perform techniques to relax before going to bed on a routine basis. These may include gently stretching, listening to quiet music or reading books or magazines. A warm bath or warm drink within 2 hours of sleep time may be helpful also. Whatever method you decide on, be sure to follow the ritual each night until it becomes a cue for your body to settle down.
12. **Use Your Bedroom for Sleep Only.** Avoid arousing stimuli. Try to avoid activities in your bedroom such as watching TV, reading or eating while in bed. Staring at an alarm clock can only serve to keep you awake. Sexual activity can be arousing or sedating. If arousing, consider a time other than the hour preceding your major sleep period.
13. **Avoid Exposure to Bright Light at Night.** If you have to get up at night, try to use subdued lighting. Exposure to bright lights is arousing and may interfere with your ability to fall asleep later on.
14. **Get Exposure to Sunlight.** Try to get ½ hour of sunlight within the first hour of awakening from your major sleep period. This will help you set your biologic sleep rhythm.

Denton Sleep Disorders Laboratory

General Suggestions – Sleep Apnea / Sleep Hygiene / Insomnia

Sleep Hygiene Measures:

1. Keep a regular sleep schedule including weekends.
2. Avoid caffeinated beverages before sleep.
3. Avoid alcohol near bedtime (no night cap).
4. Avoid smoking close to bedtime.
5. Exercise for at least 20 minutes preferably 4-5 hours before bedtime.
6. Do not engage in planning next day activities at bedtime.
7. Avoid daytime napping.

Stimulus Control:

1. Go to bed only when sleepy.
2. Do not watch TV, read or eat while in bed.
3. Use bed only for sleep and intimacy.
4. Get out of bed if unable to fall asleep in 15-20 minutes and return to bed only when sleepy. Repeat this step as many times as necessary throughout the night.
5. Set up an alarm clock to wake up at a fixed time each morning, including weekends.
6. Avoid daytime napping.

General Conservative Treatment for Obstructive Sleep Apnea:

1. Avoid alcohol, particularly in the evening.
2. Avoid sedative or hypnotics.
3. Reduce weight to ideal body weight.
4. Exercise program.
5. Avoid supine position and sleep in the lateral or prone position if apneas are noted predominantly in supine position. (Stitch a tennis ball to the pajama top to avoid sleeping in supine position.)
6. Clinical/ENT evaluation for anatomic lesion of upper airway obstruction.

Denton Sleep Disorders Laboratory

Tips Regarding CPAP

1. In order to improve compliances, educate the patient regarding the importance of treatment of sleep apnea – reduced risk of hypertension, cardiovascular abnormality, stroke, and cognitive impairment.
2. Improve CPAP compliance with appropriately fitting nasal mask according to the patient preference. Other alternative such as nasal pillows can be explored.
3. Treatment of nasal congestion or irritation with steroids spray or addition of heated humidification to the CPAP machine.
4. If the patient absolutely refuses CPAP therapy, consider referral to an ENT Surgeon with interest in sleep medicine to explore other alternative measures such as surgical intervention, oral appliances, etc.
5. If the patient continues to be symptomatic in spite of compliance with CPAP, consider follow up titration.