North Kansas City Hospital

Diagnostic Sleep Center

Multiple Sleep Latency Test (MSLT)

Prior to your Tests, you will be scheduled for a Pre-Sleep Study phone call. If you are not consistently getting at least 7 hours of sleep per night, please contact our office prior to your appointment, as it may need to be adjusted. We will begin by discussing your sleep schedule, going over your medication list, (the doctor may request specific medications or THC products be held prior to testing), discussing what you should bring addressing any questions you may have, and filling out your 2 week Sleep Diary. (If not provided by the Physician, a copy is attached below, if you do not have access to a printer please contact us so that one can be mailed to you.)

Test Overview:

It is important that you carefully fill out the two week Sleep Diary. The Diary must be completed and brought with you to your overnight Sleep Study. If you do not complete and bring the diary, your Studies will need to be rescheduled.

The MSLT immediately follows an overnight sleep study the night before*. Plan on being at the Sleep Diagnostic Center overnight from approximately 8:00-8:30 PM to sleep overnight and the next day until approximately 4:30 PM (times may vary depending on your sleep schedule and testing results). If you work at night and sleep during the day, the tests will be scheduled to fit your sleep/wake schedule. *In some instances, if appropriate based on the results of your overnight study, the Sleep Physician may cancel the MSLT, if warranted.

The MSLT is scheduled as a series of 5 "naps" given at two-hour intervals, starting approximately two hours after you wake up from your overnight study. The naps are approximately 15 to 35 minutes long, depending on if/or when you might fall asleep. This test measures your ability to fall asleep during the day at various times. It measures if you fall asleep, and the type of sleep you have.

Between the naps, you are to stay awake, and are not permitted to lay in bed. You will be able to move around and perform activities (i.e. be on your phone, computer, tablet, (Wi-Fi is available) watch television, and read as you wish, even go outside if the weather permits between naps.) Electronic devices and/or phones will need to be turned off during naps.

We will provide a box breakfast and box lunch for you. (Breakfast usually consists of cereal, milk, hardboiled egg and muffin, lunch usually consists of turkey lunchmeat with a bun, fruit and juice) You are more than welcome to bring your own meals/snacks or have food delivered*. A refrigerator is available at the Diagnostic Sleep Center. *Please, no caffeinated food or drink, as caffeine will not be allowed during this study.

It is also important to try to stay on your regular sleep routine, during the two weeks before this test. (Unless, your Sleep Medicine Physician has asked you to modify your schedule.) If something happens that requires a significant change in your sleep schedule during the 2 weeks before this study, please contact the Sleep Diagnostic Center to discuss if you need to reschedule your tests. If you become ill, you will need to reschedule your tests.

Please continue to take your regular medications as directed by your physician, unless you have been specifically directed to hold a medication. (This will be confirmed during your Pre-Sleep phone call, i.e. THC products need to be held usually 30 days prior to testing. Other medications such as stimulants, SSRIs, etc. will be discussed with the Physician if necessary). If you currently take a stimulant medication, you will not take it the morning of your MSLT but, please have it available to take if needed following the MSLT.

If you have any questions, please contact the Diagnostic Sleep Center at (816) 691-5096.

Sleep Disorder Center - 2 Week Sleep Diary

Sleep Disorder Center
Phone: 816.691.5096
Fax: 816.346.7096

Instructions: Fill out the Sleep Diary for 2 weeks leading up to your scheduled study. Bring the completed Sleep Diary to your appointment.

- **If you are not consistently getting at least 7 hours of sleep per night, please contact our office prior to your appointment.**

Start Date:	**Example Date**	Day 1 Date	Day 2 Date	Day 3 Date	Day 4 Date	Day 5 Date	Day 6 Date	Day 7 Date	Day 8 Date	Day 9 Date	Day 10 Date	Day 11 Date	Day 12 Date	Day 13 Date	Day 14 Date
	1 / 10														
During the day															
I took a nap: (circle one)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
If Yes, for how long?	**30 min.**														

Approximately 2-3 hours before going to bed, I consumed: (put a check mark in corresponding box)

Caffeine															
A heavy meal															
Alcohol															
Not applicable	✓														

Complete in the morning, after sleeping

I was awake for 30 minutes or longer during the night: (circle one) If applicable, subtract time from total hours slept.															
	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
If Yes, for how long?	**1 hour**														

I fell asleep at:	**10:00 pm**														
I woke up for the day at:	**6:00 am**														
• I slept a total of: (Hours/minutes)	**7 hours**														

IDIOPATHIC HYPERSOMNIA SEVERITY SCALE **Based on your symptoms during the past month:**

1. What for you is the ideal duration of night-time sleep (at the weekend or on holiday, for example)?
   (3) 11 hours or more (2) > 9 hours and < 11 hours (1) between 7 and 9 hours (0) < 7 hours _____

2. When circumstances require that you get up at a particular time in the morning (for example for work or studies, or to take the children to school during the week), do you feel that you have not had enough sleep?
   (3) always (2) often (1) sometimes (0) never _____

3. Is it extremely difficult for you, or even impossible, to wake in the morning without several alarm calls or the help of someone close?
   (3) always (2) often (1) sometimes (0) never _____

4. After a night's sleep, how long does it take you to feel you are functioning properly after you get up (in other words fully functional, both physically and intellectually)?
   (4) 2 hours or more (3) > 1 hour but < 2 hours (2) between 30 minutes and 1 hour (1) < 30 minutes
   (0) I feel I am functioning properly as soon as I wake up _____

5. In the minutes after waking up, do you ever do irrational things and/or say irrational things, and/or are you very clumsy (for example, tripping up, breaking things or dropping things)?
   (3) always (2) often (1) sometimes (0) never _____

6. During the day, when circumstances allow, do you ever take a nap?
   (4) very often (6-7 times a week) (3) often (4-5 times a week) (2) sometimes (2-3 times a week)
   (1) rarely (once a week) (0) never _____

7. What for you is the ideal length of your naps (at the weekend or on holiday, for example)? Note: if you take several naps, add them all together
   (3) 2 hours or more (2) > 1 hour and < 2 hours (1) < 1 hour (0) no naps _____

8. In general, how do you feel after a nap?
   (3) very sleepy (2) sleepy (1) awake (0) wide awake _____

9. During the day, while carrying out activities that are not very stimulating, do you ever struggle to stay awake?
   (4) very often (at least twice a week) (3) often (4-7 times a week) (2) sometimes (2-3 times a week)
   (1) rarely (once a week or less) (0) never _____

10. Do you consider that your hypersomnolence has an impact on your general health (i.e. lack of energy, no motivation to do things, physical fatigue on exertion, decrease in physical fitness)?
   (4) very significant (3) significant (2) moderate (1) minor (0) no impact _____

11. Do you consider that your hypersomnolence is a problem in terms of your proper intellectual functioning (i.e. problems with concentration, memory problems, decrease in your intellectual performance)?
   (4) very significant (3) significant (2) moderate (1) minor (0) no problem _____

12. Do you consider that your hypersomnolence affects your mood (for example sadness, anxiety, hypersensitivity, irritability)?
   (4) very severely (3) severely (2) moderately (1) slightly (0) not at all _____

13. Do you consider that your hypersomnolence prevents you from carrying out daily tasks properly (family-related or household tasks, school, leisure, or job related tasks)?
   (4) very significantly (3) significantly (2) moderately (1) slightly (0) not at all _____

14. Do you consider that your hypersomnolence is a problem in terms of driving a car?
   (4) very significant (3) significant (2) moderate (1) minor (0) no problem/do not drive _____

For any information on the use of the IHSS, please contact https:/eprovide.mapi-trust.org

Total Score _____