

NHMRC Centre of Research Excellence to Optimise Sleep in Brain Ageing and Neurodegeneration (CogSleep CRE)

Semi-Structured Sleep-Wake Interview for Older Adults



Client name:

DOB:MRN:

Instructions: The CogSleep Semi-Structured Interview is designed to be used in conjunction with training provided by the *Dementia Training Australia (DTA) Sleep Matters* course. Questions should ideally be asked of the patient/client but file notes, care staff, family and other health professionals may provide input, particularly if the client has cognitive impairment, dementia and/or communication difficulties.

PART 1: BACKGROUND INFORMATION (from file, or interview)

Age:	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	BMI: Height..... Weight.....
Cognitive or dementia diagnosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please specify: <input type="checkbox"/> Mild cognitive impairment <input type="checkbox"/> Vascular cognitive impairment <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Dementia with Lewy Bodies <input type="checkbox"/> Parkinson's Disease Dementia <input type="checkbox"/> Frontotemporal dementia <input type="checkbox"/> Stroke-related cognitive impairment <input type="checkbox"/> Other, please specify.....
Cognitive screen scores if known:		
MMSE:		
MoCA:		
ACE-R:		
Prior history of major depression:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, when was this?year If yes, was it treated with antidepressants?.....N/Y
Assessment for current depression?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please provide details including score <input type="checkbox"/> Geriatric Depression Scale 15 item score = <input type="checkbox"/> Cornell Scale for Depression in Dementia score = <input type="checkbox"/> PHQ-9 score = <input type="checkbox"/> Other score =
Relevant medical history:	Current Medications: <input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Sedative hypnotic <input type="checkbox"/> Melatonin <input type="checkbox"/> Tricyclics	<input type="checkbox"/> SSRIs <input type="checkbox"/> Steroids <input type="checkbox"/> Other

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PART 2: SLEEP HISTORY

1. Have you ever been diagnosed with insomnia?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, How long did it last?..... How was it treated?..... Was the treatment successful?..... N/Y
2. Have you ever been diagnosed with obstructive sleep apnoea?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, Was this diagnosed via a formal sleep study (PSG)? N/Y.... If yes, date if known..... What treatment was given (e.g. CPAP, dental splint)? Was the treatment successful? N/Y How long was it used? Is it still being used? N/Y
3. Have you ever been diagnosed with other sleep disorders?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please specify: Was this diagnosed via a formal sleep study (PSG)? N/Y.... If yes, date if known..... What treatment was given (e.g. CPAP, dental splint)? Was the treatment successful? N/Y How long was it used? Is it still being used? Y/N
4. Have you ever received treatment for another sleep disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please specify:
5. Have you used sleep medications in the past?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, What medication was used?..... Was the treatment successful? N/Y

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PART 3: NOCTURNAL SLEEP		
6. Could you rate the quality of your sleep? (1 is best, 10 is worst)	1 2 3 4 5 6 7 8 9 10	If the sleep quality rating is >5, and the patient, has difficulties getting to sleep, staying asleep or waking early, and patient has daytime sleepiness, patient should be formally screened for insomnia. Suggested tool Insomnia Severity Index
SLEEP TIMING		ACTIONS
7. Over the last week, on average what time have you gone to bed at night?	Time: pm	Consider early bed-times may contribute to circadian disturbance, nocturnal awakening and late insomnia.
8. Over the last week how long does it take you to get to sleep once in bed?	Time: mins	If longer than 20mins, are there distractions such as noise, lights, or other (e.g. residents, uncomfortable bedding). <input type="checkbox"/> No <input type="checkbox"/> Yes, specify.....
9. What time do you get up in the morning?	Time:am	If needing to be woken every morning, consider impacts on night-time sleep quality including medications, napping, excessive time in bed, lack of exercise, initial insomnia, depression, light, other disruptions.
10. Do you wake up during the night?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, a) How many times?..... b) How long would you be awake for typically?..... c) Do you primarily wake to use the bathroom? N/Y d) Do with wake up with pain? N/Y e) What do you do once you wake up? <input type="checkbox"/> stay in bed <input type="checkbox"/> turn lights on <input type="checkbox"/> watch TV <input type="checkbox"/> use phone or computer

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		<input type="checkbox"/> other, please specify.....
		f) What do you do to try and get back to sleep? g) Are there any instances of night-time wandering/confusion?
11. Do you feel refreshed in the morning after sleep?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Consider impacts on night-time sleep including sleep apnea, benzodiazepine or sedative hypnotic medications, napping, insomnia, depression, light, other disruptions
12. Do you think you are getting enough sleep?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
SLEEP APNEA (NOTE: If interviewee already has a diagnosis of sleep apnoea, proceed to Question 16)		ACTIONS
13. Do you snore or have family or caregivers ever told you that you snore?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Consider sleep apnea questionnaire including STOP-BANG , overnight oximetry or consider discussion with GP regarding polysomnography
14. Has anyone ever noticed that you gasp for air or stop breathing while you sleep?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
DAYTIME FUNCTIONING		ACTIONS
15. Do you sleep in the daytime?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Consider impacts of daytime napping on night-time sleep quality including ability to fall asleep, length of sleep, timing of sleep and depth of sleep.
16. Are you really sleepy and tired during the daytime?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Consider activities, medical conditions and medications causing daytime sleepiness, such as light levels, inactivity, meals or poor night-time sleep quality
		If yes, are you finding that you are falling asleep at times or during activities when you shouldn't <input type="checkbox"/> In the morning <input type="checkbox"/> In the early evening <input type="checkbox"/> During meals <input type="checkbox"/> During conversations <input type="checkbox"/> Sitting and watching TV <input type="checkbox"/> When reading <input type="checkbox"/> During social or recreational activities <input type="checkbox"/> After lunch

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		Does this happen <input type="checkbox"/> Rarely <input type="checkbox"/> 1-2 /week <input type="checkbox"/> 3+ <input type="checkbox"/> everyday	
17. Do you get restless/irritable/agitated in the afternoon/early evening?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
REM SLEEP BEHAVIOUR DISORDER			
18. Have you ever been told or suspected yourself that you seem to act out your dreams while asleep? (for example, punching, kicking, knocking down furniture, running movements).	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> If yes, suggested tool REM Sleep Behaviour Disorder questionnaire <input type="checkbox"/> If yes, review with GP - clonazepam may be helpful and modification of environment for safety
RESTLESS LEGS SYNDROME			
19. When you (try to relax in the evening or sleep at night do you ever have unpleasant restless feelings in your legs that can be relieved by walking or movement?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, a) Is there an urge to move legs, with uncomfortable or unpleasant sensations? b) Do the feelings begin or worsen during periods of rest or inactivity? c) Are the feelings partially or totally relieved by movement? d) Are the feelings worse in evening or night, compared to night?	<input type="checkbox"/> If yes, consider using the International Restless Legs Syndrome Rating Scale (Walter AS, Sleep Med 2013) and, also consider restless legs causing medications and other medical conditions (e.g. venous stasis, oedema, other factors such arthritis)
MEDICATION AND ENVIRONMENTAL FACTORS			ACTIONS
20. Are you taking sleeping medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, which ones:	<input type="checkbox"/> If yes, benzodiazepines, antipsychotics and sedative hypnotics should only be used for up to 2 weeks. Review with GP and consider melatonin.
21. Are you taking a combination of more than 5 medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, have you had your medication reviewed by a pharmacist?	<input type="checkbox"/> Consider pharmacy or GP medication review

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22. Has there been a recent change in residential environment?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, when?.....	
23. Do you share the room environment with other house or residential facility members?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how many?	<input type="checkbox"/> Consider noise/disruptions/comfort
24. Are you exposed to natural light during the daytime?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, when: <input type="checkbox"/> Early morning 2-3 hours after waking, for how long..... mins <input type="checkbox"/> Mid-morning to lunch, for how long..... mins <input type="checkbox"/> After lunch to early afternoon, for how long..... mins <input type="checkbox"/> Early afternoon to early sunset, for how long..... mins If no, do you get a dose of strong (greater than normal house lights, e.g. > 100 watt) light at any stage throughout the day? If no, does your residence have any built circadian lighting (e.g. blue light enriched) How long on average? hours/day	<input type="checkbox"/> Consider bright light exposure in morning and daytime <input type="checkbox"/> Consider dimming lights in evening, including screens
25. Do you engage in exercise/physical activity?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify:	Consider daytime physical activity
26. Do you in engage in cognitive activity?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify:	Consider active cognitive engagement activity (not passive activity such as TV)
27. What time do you have meals/snacks?		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Night eating?	<input type="checkbox"/> Consider sedating foods around lunchtime (e.g. pasta, carbohydrates, alcohol), and dinner foods that interfere with melatonin or are alerting (e.g. bananas, tomatoes, turkey, chocolate)

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28. Caffeine/alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Caffeine, times:Amount/ day:..... <input type="checkbox"/> Alcohol, times:.....Units/day:	<input type="checkbox"/> Consider limiting caffeine from 4pm <input type="checkbox"/> Consider limiting daytime alcohol and excessive evening alcohol
29. Is your sleep at night affected by noise or light?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify:	<input type="checkbox"/> Consider location of room, and whether nearby lights can be sensed or dimmed, earplugs
30. Night-time fluid	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify:	<input type="checkbox"/> Consider reducing evening fluids / other medications for incontinence?
31. Do you have pain at night?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, does your pain prevent you from falling asleep and wake you during the night or early morning?	<input type="checkbox"/> Consider Brief Chronic Pain scale and DTA pain module
32. Tell me about your mood?	Rate on scale from 1 to 10 (1= very low mood, 10=best)	<input type="checkbox"/> Lack of interest or pleasure in usual activities? <input type="checkbox"/> Low mood, sad, hopeless? <input type="checkbox"/> Poor appetite <input type="checkbox"/> Low energy levels <input type="checkbox"/> Withdrawn from social activities <input type="checkbox"/> Somatic symptoms <input type="checkbox"/> Feeling worthless <input type="checkbox"/> Thoughts of death, suicide	<input type="checkbox"/> If < rating 6 or cardinal depression symptoms for at least two weeks, consider, Geriatric Depression Scale 15 item score = (scores ≥ 6 may be suggestive of depression)
33. Do you have any worries or concerns that are on your mind that stop you from sleeping?	Rate on scale from 1 to 10 (10=no concerns, 1= nightly worry impacting sleep)		<input type="checkbox"/> If rating <6, explore stress, anxiety and other factors and need for relaxation strategies prior to bed- time.