Papworth Hospital NHS
NHS Foundation Trust

Assessment of leg movements in the home using the Actiwatch detector

A patient's guide

We have been asked to study your leg movements on three consecutive nights. Please continue to use any prescribed medication and keep to your usual routines.

We have programmed the movement detectors which will only work on:

Day 1: .....

Date: .....

Day 2: .....

Date: .....

Day 3: .....

Date: .....

If you are unable to use the devices on these nights please return them to us in the envelope provided with a simple note of explanation.

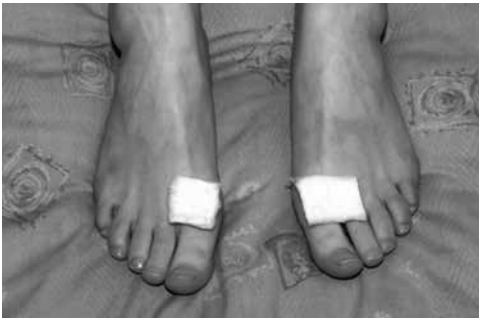
Enclosed with this booklet are:

- Two detectors in a padded envelope, cotton wool, tape and alcohol wipes
- A self-addressed envelope for you to return the detectors and the completed booklet.

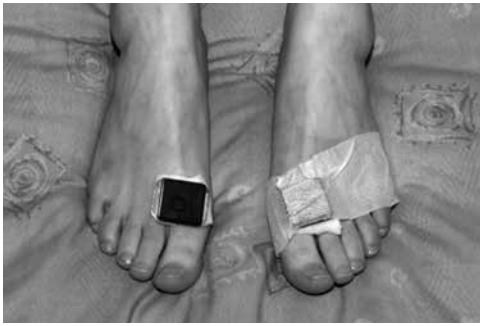
Please take care to ensure that these expensive pieces of equipment are returned to us as soon as possible.

If you have any queries please contact us on 01480 364168 between 9.00am and 5.00pm, Monday to Friday.

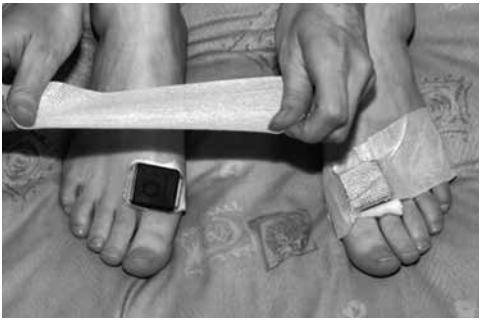
Application instructions
Please put the detectors on one hour before you go to bed



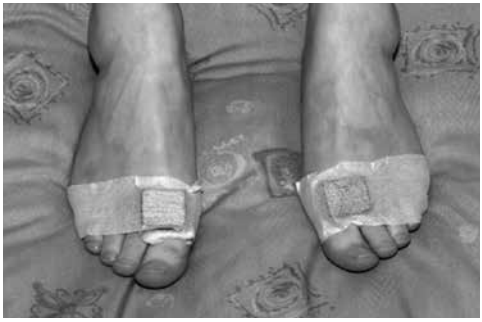
1. Place pieces of cotton wool on the base of your big toe.



2. Place the movement detector on top of the cotton wool metal side down. Note that they are marked L and R for the left and right feet.



3. Stick the tape firmly over the detector.



4. Socks can be worn over the top (if desired).

You are now set up and ready for the study to start. The movement detectors are set to start recording automatically.

The detectors should be removed when you get up in the morning. The alcohol wipes can be used to clean the detectors between nights if you wish.

Hospital number: .....

Name: .....

Date of birth: ..... /..... /..... /
Day Month Year

Please list your current medications in the table below

Name of medication	Dose	Number of times a day	Time(s) of day that you take it

Leg movement questionnaire

Please relate your answers to symptoms you have experienced over the past few weeks.

1. Do you have, or have you ever had, an urge to move your legs either accompanied with, or caused by uncomfortable or unpleasant sensations?

   ☐ Yes ☐ No

If you answered 'no' to question 1 please move on to the next page. If 'yes' please complete questions 2-7.

2. How many days during the week do you experience these sensations?

   ☐ 1-3 ☐ 4-5 ☐ 6-7

3. Do the sensations in your legs worsen when you are resting, either sitting up or when lying down?

   ☐ Yes ☐ No

4. Are the sensations in your legs either partially or completely relieved when you move/stretch or exercise them?

   ☐ Yes ☐ No

5. Do the sensations worsen in the afternoon or evening?

   ☐ Yes ☐ No

6. When do your sensations occur? (Tick all that apply)

   ☐ All day ☐ Morning ☐ Afternoon ☐ Evening

7. Do the sensations in your legs prevent you from falling asleep at night?

   ☐ Yes ☐ No

Epworth Sleepiness Scale

During the past few weeks please rate how likely you were to doze off or fall asleep, in contrast to just feeling tired, during the following situations. If you have not been in the following situations recently, try to think about how they would have affected you.

For each of the following situations please score yourself using the following scale:

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

Situation	**Score**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down in the afternoon when circumstances allow	
Sitting talking to someone	
Sitting quietly after lunch without alcohol	
In a car while stopped for a few minutes in traffic	
Total	

Sleep log

Night 1

Date: .....

What time did you go to bed? .....

What time did you settle down to try to sleep? .....

How many times did you wake up during the night? .....

What time did you finally wake up? .....

What time did you finally get out of bed? .....

Comments: .....

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Night 2

Date: .....

What time did you go to bed? .....

What time did you settle down to try to sleep? .....

How many times did you wake up during the night? .....

What time did you finally wake up? .....

What time did you finally get out of bed? .....

Comments: .....

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Night 3

Date: .....

What time did you go to bed? .....

What time did you settle down to try to sleep? .....

How many times did you wake up during the night? .....

What time did you finally wake up? .....

What time did you finally get out of bed? .....

Comments: .....

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Please post this completed log and the detectors back to Papworth Hospital in the envelope provided as soon as you have completed the study.

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Large print copies and alternative language versions of this leaflet can be made available on request.