FOCUS sleep centers

PATIENT REGISTRATION FORM

Patient Name			Birthday	SS#
			☐ Female	☐ Male
Mailing Address			☐ Married	☐ Single
City, State	Zip code	Contact Phone	☐ Divorced	☐ Widowed

If patient is a minor, Name of Parent or Guardian and Phone Number

Emergency Contact Information

Phone Number:_____
Relationship to patient:_____

Physician's Name:_____
Physician's Phone Number:_____

Primary Medical Insurance

Company Name		Phone Number	
Mailing Address		City, State, and Zip	
Primary Insurance Subscribers Name:_____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other		Subscriber Date of Birth	Subscriber SS#
Group No.	Policy No.	Effective Date	

Secondary Medical Insurance

Company Name		Phone Number	
Mailing Address		City, State, and Zip	
Primary Insurance Subscriber Name Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other		Subscriber Date of Birth	Subscriber SS#
Group No.	Policy No.	Effective Date	

Authorizations to Release Medical Information, Claim Payments, and Insurance Verifications

_____ I authorize the Focus Sleep Centers to furnish any information and records regarding the services provided to me, including information regarding psychiatric, substance abuse and communicable disease as follows; a) to any person or corporation that I indicate is responsible for paying my health care bills or that may be liable under a contract with me to pay my health care bills. This consent automatically expires when all records requirements for payment of my bills has been met, b) Health care providers have access to my health care records as needed for the purposes of continuity of care.

_____ I hereby authorize the Focus Sleep Centers to release any information regarding services rendered by them and to allow a photocopy of my signature to be used to file my Medicare and/or insurance claim, and any third party payor.

I hereby authorize Focus Sleep Centers to bill my insurance carrier and receive payment directly for service on my behalf. By signing below I am verifying the personal data on this sheet is accurate and indicating I understand the information provided.

Patient Signature:_____ Date:_____

Contact Information
P: (662) 349-9802 F: (662) 349-9810

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FINANCIAL POLICY

This for must be completed annually: Received on: _____

The Focus Sleep Centers (ASC) believes that part of good health care practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. If you are unable to meet this obligation at the time of service you must make payment arrangements prior to receiving service and/or supplies. We do ask for a copy of an ID card or license due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. INSURANCE We are participating providers with many insurance plans. We will file all insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.

If you are insured by a plan with which we have no prior arrangement, we will still prepare and send the claim in for you. If you receive payment for a service or supply furnished by our office you are expected to make payment to Focus Sleep Centers immediately.

Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

3. RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving and further services or supplies from the Focus Sleep Centers. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action.

4. ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service

5. BILLING OFFICE: If you have questions in regard to any of your billing statements, our accounts receivable staff is available to assist you. CALL 662-349-9802.

6. RESPONSIBILITY FOR PAYMENT: You understand that you, personally, are financially responsible to the Focus Sleep Centers for charges not covered by the assignment of insurance benefits.

7. DME SUPPLY LIMITATIONS: You understand that if you have benefits through a federally funded insurance plan, and the Focus Sleep Centers provided and billed for a sleep study on your behalf, then the Focus Sleep Centers is not authorized to provide Durable Medical Equipment to you. These insurances include Medicare, Medicaid, TriCare and Veterans Administration. If you are eligible for the above stated benefits the Focus Sleep Centers will assist you in locating a suppliers who can meet your Durable Medical Equipment needs. You must notify Focus Sleep Centers in writing immediately if you become eligible for one of these payers.

8. INTERPRETATION FEES: You understand that Sleep Studies performed by the Focus Sleep Centers are interpreted by a qualified Sleep Medicine Specialist. You may receive a separate billing for this service. Payment should be made directly to the interpreting physician for this service.

Your signature below confirms that you understand the above Financial Policy and agree to abide by its terms. The signing of this Financial Policy is a prerequisite to receiving any service or supply from the Focus Sleep Centers.

Signature:_____ Date:_____

AMERICAN ACADEMY OF SLEEP MEDICINE WAKE SLEEP

Contact Information

P: (662) 349-9802 F: (662) 349-9810

www.focussleepcenters.com

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Records needed for continuing medical care are provided free, there may be a charge for other requests

Name of Patient/Client (Last, First, MI)	Date of Birth	Previous or Other Names used
Address	City, State, Zip	Telephone # Alternate #

REQUESTOR MUST PROVIDE A LEGIBLE COPY OF LEGAL IDENTIFICATION WITH THIS FORM

The information is to be disclosed by:		**And is to be released to:**	
Name of KIT Agency/Department **Focus Sleep Centers**		Name of Individual Receiving Records	
Address		Agency Name and Address	
City, State, Zip		City, State, Zip	
Phone #	Fax #	Phone #	Fax #

I authorize the communication to be exchanged in/by: ☐ Writing ☐ Verbally ☐ Electronically ☐ Fax

I authorize the use/disclosure of health information about the above name individual/entity as described below for the following dates and purposes:

From _____ to _____

☐ Only information related to (Specify injury, accident or particular illness/treatment):_____

☐ Entire record for all dates of service.

☐ Billing statements for the following dates/treatment: _____

☐ Other information specified below:

Description of specific, including sensitive, information to be disclosed, please initial all applicable box(s) below:

	Medical Records		Psychological/Psychiatric Assessment
	Lab / Pathology Reports		Substance Abuse Assessment
	Radiology Reports		Mental Health Assessment
	Medication list		Discharge Summary, Plan, Status
	Dental /History /X-Ray		Diagnosis

(REQUESTOR MUST CHOOSE ONE OF THE FOLLOWING): The information will be disclosed for the following purposes

☐ Attorney
☐ Disability
☐ Insurance
☐ Military
☐ Customer Transferring Care to Other Hospital/Clinic
☐ At request of the individual or Personal Representative

Court Ordered Individuals:

____ (initials) I understand this Release of Information is a condition of my treatment and services will not be provided should I refuse to sign.

I understand that my records are protected under HIPAA and may also be further protected under 42 CFR, Part 2(substance abuse diagnosis or treatment related records). I understand these records cannot be disclosed without my written consent, unless otherwise provided for by law, and that in most cases (see exception for court ordered participation), KIT cannot condition my treatment, enrollment in a health plan, or eligibility for health care benefits on my failure to sign the authorization. I am aware that, but for records protected under 42 CFR Part 2, there is a potential that records disclosed under this authorization are subject to re-disclosure and are no longer protected under HIPAA. I am aware that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires:

_____ One year from date signed, or on: _____

Signature of Individual: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

This information has been disclosed to you from records protected by Federal Confidentiality Rules, including HIPAA and potentially 42 CFR Part 2). If these records are governed by 42 CFR Part 2, you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains to or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Verification of Identity and Authority

Form of Identification: _____ Date Received: _____

Documentation of Authority _____

☐ **Original** authorization maintained in Health Record/EHR ☐ **Copy** of form to patient

PRIVATE HEALTH INFORMATION DISCLOSURE

Acknowledgement

The department of Health and Human Services has established a "Privacy Act" to help insure that personal health care information is protected for privacy. The Privacy Act was also created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient and/or carry out treatment, payment or health care operations (TPO).

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect you privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide services that are in your best interest.

I acknowledge that I have received, or had the opportunity to receive, a full copy of my full rights regarding my personal health information. I understand that I can obtain an additional copy of these rights from this office or on the Focus Sleep Centers website (www.focussleepcenters.com) at any time.

I have reviewed and understand my rights regarding my personal healthcare information.

Signature: _____ Date: _____

Printed Name: _____

Disclosures

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule gives individuals the right to request a restriction on uses of Private Health Information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternate means, such as sending correspondence to the individual's home, work or fax number.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use and disclosure of PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

Note: Use and disclosure for Treatment, Payment and Operations may be permitted without prior consent and in emergency situations.

Communication of my Private Health Information may be handled in the following manner:

- □ Provider may mail information to my home address.
- □ Provider may mail information to my work address.
- □ Provider may leave information on my telephone: _____
  (This may include appointment reminders or information regarding visit or study results.)
- □ Provider may send information to this fax number: _____
- □ Provider may exchange information via this email address: _____
- □ Provide may send information to (name, relationship, and contact information):
  _____
  _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Focus Sleep Centers is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. Focus Sleep Centers is also required to abide by the terms of the version of this Notice currently in effect.

Uses and Disclosures of PHI: ASC may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

For treatment. This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI via radio or telephone to the hospital or dispatch center.

For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts.

For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

Reminders for Scheduled Appointments and Information on Other Services. We may also contact you to provide you with a reminder of any scheduled appointments or to provider information about other services we provide.

Use and Disclosure of PHI Without Your Authorization: ASC is permitted to use PHI *without* your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including:

- For the treatment, payment or health care operations activities of another health care provider who treats you;
- For health care and legal compliance activities;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests;
- To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence;
- For health oversight activities including audits or government investigations,
- inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when responding to a warrant;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals;
- We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Patient Rights: As a patient, you have a number of rights with respect to your PHI, including:

The right to access, copy or inspect your PHI. This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If you wish to inspect and copy your medical information, you should contact our privacy officer.

The right to amend your PHI. You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request that we amend the medical information that we have about you, you should contact our privacy officer.

The right to request an accounting. You may request an accounting from us of certain disclosures of your medical information that we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, like our billing company or our Medical Director who interprets your study results. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting, contact our privacy officer.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you. Focus Sleep Centers is not required to agree to any restrictions you request, but any restrictions agreed to by Focus Sleep Centers in writing are binding on Focus Sleep Centers.

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request. If we maintain a web site, we will prominently post a copy of this Notice on our web site. If you allow us, we will forward you this. Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice: Focus Sleep Centers reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting our privacy officer.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to our privacy officer.

Effective Date of this Notice: March 8th, 2017

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Information and Patient Releases

Initial Below

_____ In order to collect a complete and detailed sleep study that will enable the physician(s) providing my care to effectively diagnose and treat my sleep condition, I, the undersigned, consent and authorize photographic, video, and/or audio data to be recorded during the testing procedure.

_____ I further authorize the subsequent use of my photographic, video, and/or audio recording to be used for the furtherance of medial science and/or for medical education purposes. I consent to the presentation of all relevant medical information and clinical demonstration concerning my/this case to students of medicine and allied health sciences, to medical professional groups, and to the possible publication thereof in scientific literature. Anonymity will be insured.

_____ Sleepiness causes auto crashes because it impairs your reaction time and attention and ultimately can lead to you falling asleep at the wheel.

Although no driver is immune to drowsy driving-related accidents, there are higher risks to some populations. People with untreated sleep apnea, narcolepsy or other sleep disorders are at higher risk for driving-related accidents.

Upon completion of a physician directed sleep disorders test performed at **Focus Sleep Centers** you have been provided written explanation of the consequences and are hereby advised against driving until such time as you have been evaluated, diagnosed and successfully treated by a physician for any sleep disorder that can impair your ability to safely operate a motor vehicle, and until such time as all symptoms of excessive sleepiness have been successfully resolved.

My signature below confirms I have read and understand the above paragraphs. My initials above indicate my consent to and/or acknowledge the information presented.

Signature: _____

Date: _____

Witness to Signature: _____

Date: _____

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Have you ever had a sleep study? ❒ **Yes** ❒ **No**

If you answered *NO*, ignore this page. If *YES*, please provide a copy of your sleep study records if possible.
Please bring your current CPAP or Bilevel machine and mask if applicable, and answer the following questions:

When was your previous sleep study? _____

Where was your previous sleep study? _____

What were the study results? _____

Are you currently using CPAP or a Bilevel machine at home? ❒ **Yes** ❒ **No**

If yes, what is your treatment setting? _____

Please indicate the brand, model and age of the machine: _____

_____

Do you expect to be replacing your old machine? ❒ **Yes** ❒ **No**

What type of mask are you using, how old is it, and are you happy with its performance?

_____

Please describe why you need a sleep study at this time:

_____

_____

_____

_____

_____

_____

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Patient Questionnaire

Patient Name:_____ Date:_____

Age:_____ Height:_____ Weight:_____ Marital Status:_____ Referring Physician:_____

Why Are You Here? (Reason for the study in your own words):_____

_____Occupation: _____

Sleep Schedule

1. What time on weekdays do you usually — Go to bed?_____ Wake up? _____
   What are your usual working hours if applicable — Begin? _____ End?_____
2. What time on weekends do you usually — Go to bed?_____ Wake up? _____
3. On average, how long do you actually sleep at night? — Weekdays? _____ Weekends? _____
4. Do you feel you get too much or too little sleep at night? — Too much?_____ Too little? _____

Night Time Symptoms

5. How long does it normally take you to fall asleep at night? Mins _____
6. Do you have thoughts that prevent sleep? Yes _____ No _____
7. Do you have trouble getting to sleep at night? Yes _____ No _____
8. Do you awaken at night to use the bathroom? Yes _____ No _____How often? _____
9. Are you ever awakened by a "coughing spell" during the night? Yes _____ No _____
10. Do you have crawling sensation in your legs when falling asleep? Yes _____ No _____
11. Do you have twitching movements in your legs during the night? Yes _____ No _____
12. Do you awaken with racing thoughts, sadness or anxiety? Yes _____ No _____
13. Have other people told you that you have restless sleep? Yes _____ No _____
14. Do you have difficulty going back to sleep during the night? Yes _____ No _____
15. Does anyone tell you, you snore badly? Yes _____ No _____
16. Do you have difficulty breathing at night? Yes _____ No _____
17. Do you wake up with headaches? Yes _____ No _____ How often? _____
18. Do you awaken with a sour or bitter taste in your mouth? Yes _____ No _____ How often? _____
19. Is it difficult for you to awaken & get out of bed after sleeping? Yes_____ No _____ How often? _____
20. Have you experienced paralysis upon awakening from sleep? Yes _____ No _____ How often? _____
21. Do you have vivid dreams as you are falling asleep? Yes _____ No _____ How often? _____
22. Is your sleep disturbed by a medical problem (Y/N)?_____ Describe:_____

Day Time Symptoms

23. Do you deliberately take naps during the day Yes____ No _____How often? _____How long? _____
24. Do you feel rested or refreshed after a nap? Yes _____ No _____
25. Are you bothered by sleepiness during the day? Yes _____ No _____ How often? _____
26. Do you find yourself falling asleep when you don't mean to? Yes _____ No _____ How long? _____
27. Do you take naps during the day? No Need _____ I want to but can't _____ Number of times a week _____

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28. Do you fall asleep during these situations?
0 = no chance of dozing, 1 = slight chance of dozing, 2 = moderate chance of dozing, 3 = high chance of dozing

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place?	0	1	2	3
As a passenger in a car for an hour with out a break	0	1	2	3
Lying down to rest in afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

_____ **Total**

29. Have you noticed, or been told about, any changes in your personality recently, such as:

a) irritability Yes_____No _____
b) increased temper Yes_____No _____
c) anxiety Yes_____No _____
d) depression Yes_____No _____
e) loss of concentration Yes _____ No_____
f) "spaced out" feeling Yes _____ No_____
g) decreased job productivity Yes _____ No_____
h) poor memory Yes _____ No_____

30. Have you ever had the following kinds of weakness develop suddenly during an emotional situation (for example, when laughing, if angry, if in an exciting situation, etc.)? (Check one on each line):

	Never	1-5 times in your life	Monthly	Weekly	Daily - almost daily
Knees buckling					
Mouth opening					
Head nodding					
Falling down					

Do you know, or others tell you that you:	Age Started	Last Occurred	Frequency	Treatment
Talk while apparently asleep?				
Walk while apparently asleep?				
Grit teeth while apparently asleep?				
Wake up screaming, anxious or afraid?				
Have disturbing dreams (nightmares)?				
Have unusual movements while asleep?				

Health History?

☐ Weight Problems	☐ Tonsillectomy	☐ Lung Disease	☐ Heart Disease	☐ Stroke
☐ High blood pressure	☐ Sinus Surgery	☐ Ulcers	☐ Neurologic Disease	☐ Cancer
☐ Shortness of breath	☐ Chronic Cough	☐ Colitis	☐ Anxiety	☐ Narcolepsy
☐ Deviated nasal septum	☐ Chronic Bronchitis	☐ Kidney problems	☐ Dementia	☐ Chronic Fatigue
	☐ Asthma	☐ Thyroid Disorder	☐ Depression	☐ Fibromyalgia
☐ Sinus Problems	☐ Emphysema	☐ Diabetes	☐ Psychiatric	☐ Parkinson's

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31. Please list any other health or surgical history _____
_____
_____
_____
_____

32. If anyone in your family had sleep problems, please list the problem & your relationship _____
_____

33. For each of the beverages listed below, please write the average amount you drink daily:
Regular coffee(Cups)_____Hot or iced tea (Cups) _____ Caffeinated soft drinks ___

34. Do you smoke cigarettes (Y/N)? _____
If YES, how many packs per day? _____ For how many years? _____
If NO, did you ever smoke?_____ When did you stop smoking? _____

35. How many alcoholic beverages do you drink per day during the week?_____ or per month?_____

36. *Please list medications below or attach to the back of this questionnaire*

Medications	Amount	How Often	Years	Reason

If there are any other aspects that you feel are important, please describe them here

_____
_____
_____
_____
_____

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Bed Partner Questionnaire

Patient Name: _____ Date: _____

Your Name: _____ Relationship:_____

I have observed this person's sleep (circle one): Never Once or twice Often Every night

Check any of the following behaviors that you have observed this person doing while asleep. *Circle* those that you consider severe problems.

____ Light snorer
____ Moderate snorer
____ Loud snorer
____ Occasional loud snorts
____ Choking
____ Pauses in breathing
____ Sleep talking
____ Bed-wetting
____ Awakening with pain
____ Getting out of bed not awake
____ Becoming very rigid and shaking
____ Twitching or kicking of legs
____ Grinding teeth
____ Sitting up in bed not awake
____ Head rocking or banging
____ Biting tongue
____ Crying out
____ Other_____

If this person snores, what makes it worse?

____ Sleeping on his/her back
____ Sleeping on his/her side
____ Fatigue
____ Alcohol

Please describe the behaviors checked in more detail. Describe the time when it occurs, how often it occurs during the night, and whether it occurs every night.

_____
_____
_____
_____
_____

Has this person fallen asleep during normal daytime activities or in dangerous situations? Yes / No

If yes, please explain: _____
_____
_____

Does this person use sleeping pills? Yes / No What kind? _____How often? _____

Does this person drink alcohol? Yes / No If yes, estimate the per week use of:
12 oz. Beer_____ 6-8 oz. Glasses of Wine_____ 1-1/2 oz of hard liquor_____

Please estimate how much alcohol this person consumes in the 3 hours before bed: _____

If this person uses recreational drugs, please describe both the types and frequency of usage: _____

_____

Sleep Diary

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
I went to bed last night at ___:___ (time):							
I got out of bed at ___:___(time):							
Last night, I fell asleep in ____ (Mins):							
When I woke up for the day I felt:	Refreshed Slightly refreshed Fatigued	Refreshed Slightly refreshed Fatigued	Refreshed Slightly refreshed Fatigued	Refreshed Slightly refreshed Fatigued	Refreshed Slightly refreshed Fatigued	Refreshed Slightly refreshed Fatigued	Refreshed Slightly refreshed Fatigued
Last night I woke up ___ times:							
My sleep was disturbed by:							
Number of caffeinated beverages in the morning:							
Number of caffeinated beverages in the afternoon:							
Number of caffeinated beverages in the evening:							
I exercised 20 mins or more at ___:___ (Time):							
Number of alcoholic beverages before bedtime:							
Medications I took during the day:							
I did what activity within an hour before bed:							

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You are scheduled for a sleep study on: _____ at _____.

Please review and complete the following forms as completely as possible prior to your sleep study:

- ❒ Patient Questionnaire
- ❒ Sleep Diary
- ❒ Bed Partner Questionnaire, if applicable

Instructions for the day of your sleep study

Do

- ✓ Do bring your regular, prescribed medications to take according to your physician's instructions
- ✓ Do bring sleeping clothes such as pajamas or shorts and t-shirt
- ✓ Do bathe and have your evening meal prior to coming to the sleep clinic
- ✓ Do bring a favorite pillow or blanket if desired
- ✓ Do bring reading material if desired

Do Not

- ✓ Do not take any naps during the day
- ✓ Do not drink or eat anything containing caffeine such as coffee, chocolate, tea, soda, etc. after 11:00am
- ✓ Do not use hair sprays, leave in conditioners or hair oils

What to expect when you arrive for your sleep study:

When you arrive at the clinic a sleep technologist will help you complete any additional paperwork, explain the testing procedure, and answer any questions you may have. The sleep technologist will then apply several sensors to record brain activity, eye movements, muscle movements, heart rate, and other parameters. All of the sensors are completely non-invasive and painless. You will sleep in a private, comfortable room with a restroom available nearby. The technologist will be in the clinic throughout testing to provide for your safety and monitor the recording. A minimum of six hours of recording time is necessary, and no electronic items such as radios, TVs, cell phones, etc. are allowed to be used once the study has begun.

What to expect when you receive your bill:

A Sleep Physician will analyze and interpret the sleep study results. The charge for this interpretation is separate and will be in addition to the charges for the sleep study. Any additional medical supplies such as CPAP equipment will also be billed separately.