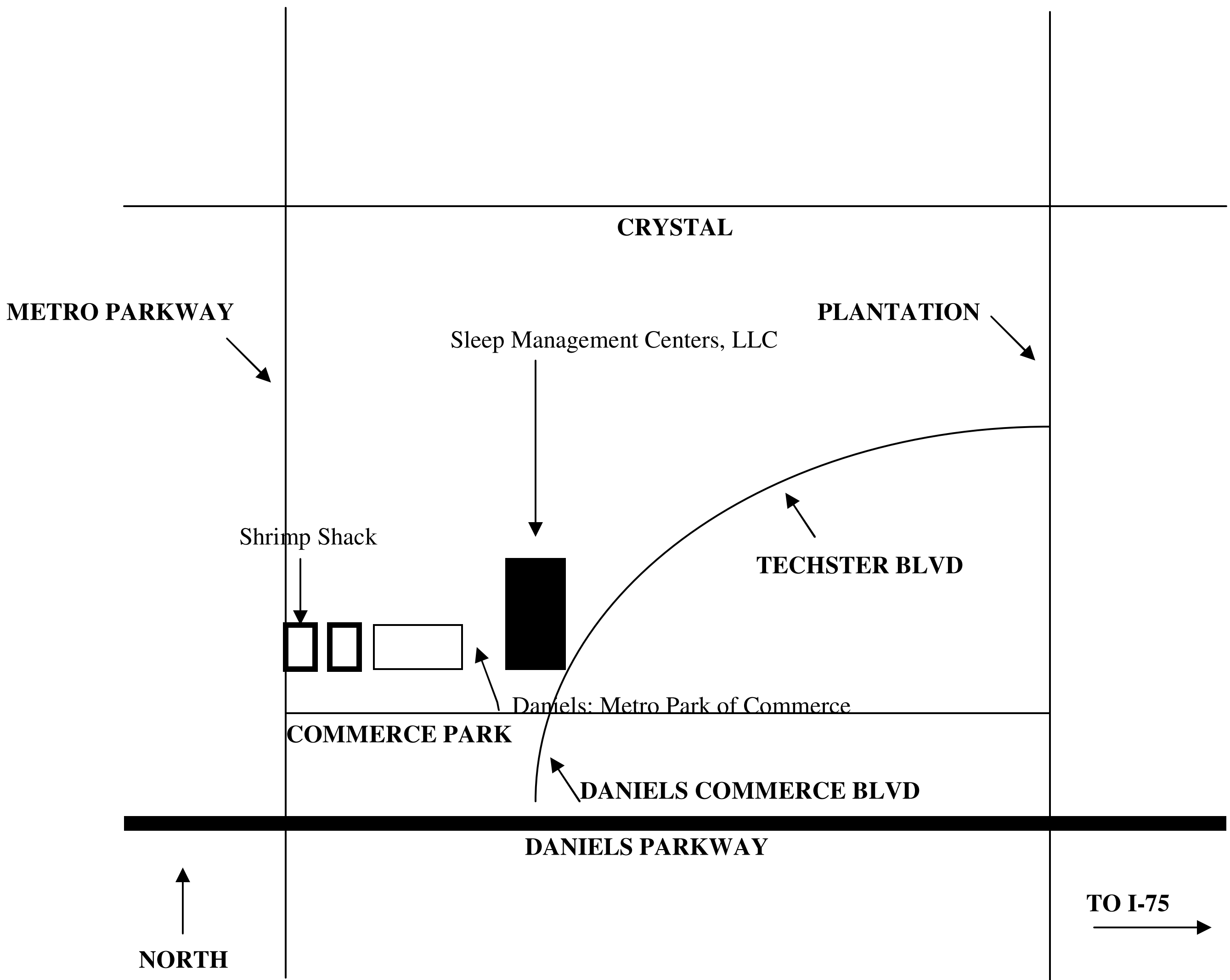
SLEEP Management Centers LLC

SLEEP STUDY INFORMATION PACKET



If you have to call after 5:00pm, please call (239) 210-0046.

RE: Patient Name: ____

Sleep Study Scheduled for: ___________________________________

Additional Testing or Appointments: ___________________________

Dear Patient:

Your doctor has scheduled you for sleep studies at Sleep Management Centers, LLC on the dates noted above. Please read the following information carefully prior to your appointment, and call us if you have any questions. We will verify your insurance and inform you of any co-pays and deductibles prior to your study.

Call and Confirm

It is very important that you call to confirm your appointment the day before or the day of your study. If you must reschedule your appointment, **kindly give us 24 hours notice so that we may fill your space with another patient.**

On the day of your study:

- DO NOT DRINK ANY CAFFEINATED BEVERAGES after 2:00pm the day of your study. You should not take any naps during that day, even if that is normal for you.

- Please arrive with clean, dry hair without oils or creams applied. If you usually shower in the evenings, please do so before you arrive. Men should be freshly shaven, unless a beard or mustache is worn.

- You should eat a typical evening meal before arriving at the center. If you normally drink alcohol, please do not come to the sleep center intoxicated.

- Bed partners are not permitted during the sleep study, nor are electrical appliances allowed in the room. Cell phones must be **turned off** during the testing phase of the study. Persons requiring special assistance should notify us prior to the study at the time the appointment is confirmed.

What to bring:

- The completed questionnaires and any insurance authorization or referral forms.

- Comfortable, two-piece pajamas are preferred. Ladies should not wear one piece nightgowns. Also, the restrooms and setup room may be separate from your bedroom, so you may wish to bring a robe and slippers.

- Any medications you normally take. NO medications are available at our facility.

- Reading material if you normally read prior to sleeping. A television with satellite TV and a DVD playing system is available in your room and in the patient lounge.

- Toiletries you use in the evening or morning, such as tooth paste and tooth-brush (soap and shampoo are provided for you). Showers are available for use prior to leaving in the morning if you need to go directly to work.

- Items you usually use when you sleep, such as a favorite pillow or blanket.

What to expect

- You will be shown to a private bedroom. After changing into sleepwear, the technician may escort you to another room where he/she will attach small electrodes with adhesive to the surface of your scalp, near your eyes, on your chest, legs, and chin. The monitoring is all non-invasive (no needles or shots). After the electrodes are in place, you will be escorted back to your bedroom.

- Most patients find that they are able to move in bed quite easily, even with the electrodes in place. If you need to use the bathroom, the technician should be called in to unplug the monitors first. Each room has a passive intercom system for your communication.

The next morning

In the morning, you will be awakened around 6:00am. All of the electrodes and other equipment will be removed and you will be free to leave. All testing and cleanup should be completed by approximately 7:00am. ***If you are being picked up, please arrange for your ride to be here by then.*** Patients who are not scheduled for daytime testing are not permitted to remain at Sleep Management Centers, LLC during the day, due to the disturbance it may create while others are being tested. However, if you are scheduled for a study again that night, you may store personal belongings in your bedroom until you return.

MSLT studies

If you doctor has ordered a daytime multiple sleep latency test the day after your night study, we will provide breakfast and lunch. A refrigerator and microwave are also available.

How to get here

Sleep Management Centers, LLC is located at 6350 Techster Blvd., Suite #2. We are near the corner or Metro Parkway and Daniels Parkway. From Daniels Parkway going west, turn right onto Metro Parkway. Go one block to Commerce Park and Turn right (at the Shrimp Shack). Approximately 1/8 mile turn left into **Daniels: Metro Park of Commerce.** Our building is the first one on the right. There is ample parking in front of the building.

We would like to make your study as successful as possible. Please call us at (239) 334-8144 or (239) 210-0044 in the evenings if you have any questions or require special arrangements.

Sincerely,

Andrea L. Clark, MSW, RPSGT
Administrator

SLEEP Management Centers LLC

6350 Techster Blvd., Suite #2, Fort Myers, FL 33966 Telephone: (239) 334-8144 Fax: (239) 210-0048

Patient Registration

Last Name: ___________________________First Name: _____________________________MI: ________

Sex: M F Date of Birth: _____________________ Social Security #: ______________________

Marital Status: M S W O

Local Address: _________________________ City: __________________ St: ____ Zip Code: _________

Local Phone: _______________________________Cell/Work phone: ______________________________

Out of State Address: __________________________ City: ___________________ St: ____ Zip Code: _______

Out of State Phone: ______________________________ Months there: _____________________________

Primary Insurance: ________________________ Policy #: ____________________ Group #:___________
(what state) _________
Secondary Insurance: _______________________ Policy #: ____________________ Group#: ___________
(what state) _________

Referring/ Primary Physician: ____Phone: ______________

Pharmacy: ___________________________ Location: _______________________Phone: ______________

In case of an emergency contact: _______________________________ Relationship: __________________

Phone: _________________________________

Do we have permission to?

Leave a message on your answering machine? YES NO
Discuss your medical condition with anyone? YES NO
If yes, please provide their name/relationship to you. _____________________________________

I hereby authorize any insurance benefits to be paid directly to the physician/center providing services and recognize any responsibility to pay for all non-covered services. I also authorize the physician/center and insurance company to release any information necessary to process an insurance claim, medical authorization, or any request for medical records or payments.

I have been presented with a copy of Sleep Management Centers, LLC's HIPPA Notice of Privacy Practices, dealing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restrictions concerning the use of my personal medical information: ____
Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment

Patient's signature: ____ Date: __________________________

Witness signature: ____Date: __________________________

How did you hear about us? ____

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Initial Questionnaire

Name: ____

1. What is your height? _______feet _______ inches
2. What is your weight? ___________pounds
3. What is/was your occupation? ________________ Retired? YES NO
4. Are you a shift worker? YES NO IF so, what shift? ____________
5. What time do you go to bed on WEEKDAYS? ____________ AM or PM
6. What time do you wake up on WEEKDAYS? ____________ AM or PM
7. What time do you go to bed on WEEKENDS? ____________ AM or PM
8. What time do you wake up on WEEKENDS? ____________ AM or PM
9. Do you nap during the day? YES NO
   A. How often do you nap? _____________________
   B. How long are your naps? _____________________minutes
   C. Do you awaken refreshed? YES NO
10. Do you fall asleep while watching TV after work? YES NO
11. Do you require any special bed or bathroom arrangements or assistance for sleeping (such as wheelchair access, mattress cover) or the restroom? YES NO
    A. If yes, what? ____
12. Are you a current/former smoker? CURRENT FORMER NON SMOKER
    A. Type? (cigars, pipes, cigarettes……) ____________
    B. How long have you smoked? ____________ years
    C. How many packs a day do you smoke? ____________
    D. If former, when did you quit? ___________
13. Do you drink alcohol? YES NO
    A. How much do you consume on a daily basis? _______________________
14. How many caffeinated beverages do you drink per day?
    E. Coffee ______________
    F. Tea ________________
    G. Soft drink ___________
15. Do you have any pets in the home? YES NO
    A. Type? _________________________
16. Have you ever been exposed to dusts, asbestos, mining, etc? YES NO
    H. If yes, please list.

    ____

    ____

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Health & Family Questionnaire

1. What problems are you having that made you seek our help?
   ___
   ___
   ___

2. How does this problem affect your life?
   ___
   ___
   ___

Please list all medications you currently take.

Name of Medication	Dosage/frequency	How long have you been taking this	Reason

(Please let us know if you need another drug sheet)

3. Do you have any food or drug allergies? YES NO
   A. If yes, please list. ___

4. Have you had any hospitalizations or surgeries? YES NO
   A. If yes, please list type and dates.___
   ___
   ___

Please check the box for each problem you **CURRENTLY HAVE**.

Loud snoring
Frequent awakenings at night
Choking for breath at night
Gasping during sleep
Awaken un-refreshed
Sweating a lot at night
Restlessness during sleep
Morning headaches
Doing things that make no sense, such as writing nonsense or mixing gravy with chocolate

Crawling feelings in legs when trying to sleep
Feeling paralyzed or unable to move when falling asleep
Dream-like images just after waking up
Sudden muscular weakness during strongly emotional times
Trouble falling asleep at night
Waking too early in the morning
Tongue biting in sleep
Uncontrollable daytime sleep attacks
Falling asleep unexpectedly
Falling asleep with driving

Morning dry mouth
Sleep talking
Sleepwalking
Nightmares
Leg-kicking during sleep
Bedwetting
Acting out dreams
Falling asleep at work/school
Pain interfering with sleep
Where is the pain?
___

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Please check any of the following health problems you have now or have had in the past.

Diabetes	Now	Past	Anemia	Now	Past
High Blood Pressure	Now	Past	Peptic Ulcers	Now	Past
Stroke	Now	Past	Acid Reflux (Heartburn)	Now	Past
Heart Disease of CHF	Now	Past	Kidney Disease	Now	Past
Heart Attack	Now	Past	Thyroid Disease	Now	Past
Angina	Now	Past	Arthritis	Now	Past
Emphysema	Now	Past	Back Pain	Now	Past
Asthma	Now	Past	Head Trauma	Now	Past
Tuberculosis	Now	Past	Severe Headaches	Now	Past
Other Lung Disease	Now	Past	Epilepsy (Seizures)	Now	Past
Nasal Allergies	Now	Past	Passing Out Spells (Fainting)	Now	Past
Runny or Blocked Nose	Now	Past	Depression	Now	Past
Hormonal Problems	Now	Past	Anxiety Disorder	Now	Past
Urological Problems	Now	Past	Problems with Alcohol	Now	Past
Prostate Disease	Now	Past	Problems with Drugs	Now	Past

How would you rate your current health?
VERY POOR   POOR   AVERAGE   GOOD   VERY GOOD

Please give us important details about your medical condition.

____
____
____
____
____

Family Information

1. Is your father living? YES NO   If yes, how old is he? __________

   If no, at what age did he die? __________   What caused his death? __________________

2. Is your mother living? YES NO   If yes, how old is she? __________

   If no, at what age did she die? __________   What caused her death? __________________

3. Please list your brothers and sisters below with their age they are now (if living) or the age they were (at death) and list the cause of death.

Name	Age Now	Age at death	Reason for death

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To the best of your knowledge, please check below all that apply.

	Father	Mother	Brother	Sister	Child	Other
Goiter						
Diabetes						
Obesity						
Urological Problems						
Tuberculosis						
Emphysema						
Asthma						
Sever headaches						
Epilepsy						
Cancer						
Blood Disease						
Hormonal Problems						
Allergies						
Depression						
Trauma						
Anemia						
Heart Attack						
Angina						
Stroke						
High Blood Pressure						
Ulcers						
Colitis						
Nervous Trouble						
Arthritis						
Gout						
Kidney Disease						
Prostate Disease						
Problems with Alcohol						
Problems with Drugs						
Periods of Unconsciousness						

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EPWORTH SLEEPINESS SCALE

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 these things recently, try to work out how they would have affected you. Please check one box per line.

0= would never dose
1= slight chance of dosing
2= moderate chance of dosing
3= high chance of dosing

Situation	**Chance of Dozing off**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total: ___________________

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Catalyst Questionnaire

This questionnaire will further help your physician with your sleep assessment.

1. Do you or have you ever experienced episodes of muscle weakness, loss of muscle strength, or limp muscles in any part of your body during the following situations?

When you laugh	YES	NO
When you are angry	YES	NO
When hearing or telling a joke	YES	NO

If **YES** to **any** of the above please answer the following (if NO to all, go directly to question 2)

How often do these episodes occur?
Only a few times in your life   Yearly   Monthly   Weekly   Daily

How long do these episodes usually last?
5 seconds or fewer   5 seconds to 10 minutes   more than 10 minutes

Do you remain awake and aware during these episodes?   YES   NO

During these episodes, do you feel or have (check all that apply):

Leg weakness	Head drop	Knee buckling	Arm weakness
Neck weakness	Fall to the ground	Face sagging or jaw dropping	Slurring of speech

Other (specify): ____

How old were you when the first episode occurred? ______________________

Please describe this experience. ______________________________
____
____

When was the most recent episode? ______________________________

Please describe this experience. ______________________________
____
____

Do you or have you ever avoided emotional situation or held back your emotions in order to prevent these episodes?	YES	NO
Do these episodes interfere in any way with your work?	YES	NO
Do these episodes interfere in any way with your personal life?	YES	NO

2. Have you ever experienced episodes of muscle weakness, loss of muscle strength, or limp muscles in any part of your body during any of the following situations?

When tense or under stress	YES	NO
During or after exercise	YES	NO

Other (if yes, please specify):

____