

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **Sleep Apnea Questionnaire**

*Please check all comments that apply to you:*

- I sometimes suffer from daytime sleepiness.
- I doze off in church on occasion.
- If I doze off, I sometimes wake up and “snort”.
- I have been told that I hold my breath or stop breathing in my sleep or a minimum of 10 seconds.
- I have high blood pressure.
- I toss and turn a lot in my sleep.
- I get up to visit the bathroom more than once a night.
- I often feel sleepy and struggle to stay alert, especially during afternoon meetings.
- I sometimes fall asleep while watching television.
- I have fallen asleep while driving.
- I sweat excessively during the night.
- I have been told that I kick in my sleep.
- I wish I had more energy and less fatigue.
- My neck measures over 17 inches (male) or 16 inches (female).
- I am more than 15 pounds overweight.
- I seem to be losing my sex drive or my ability to perform in bed.
- I sometimes get heartburn in the middle of the night.
- I sometimes wake with a bad taste in my mouth, or a dry mouth and throat.
- I frequently feel depressed.
- I sometimes wake with a pounding or irregular heartbeat.
- I feel as if I am getting old too fast.
- I often get morning headaches.
- My friends and family say I am sometimes grumpy and irritable.
- I have short term memory problems.
- I do not feel rested or refreshed, even after 8 or 10 hours of sleep.
- I am tired all of the time.
- I have difficulty concentrating.

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## Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate:

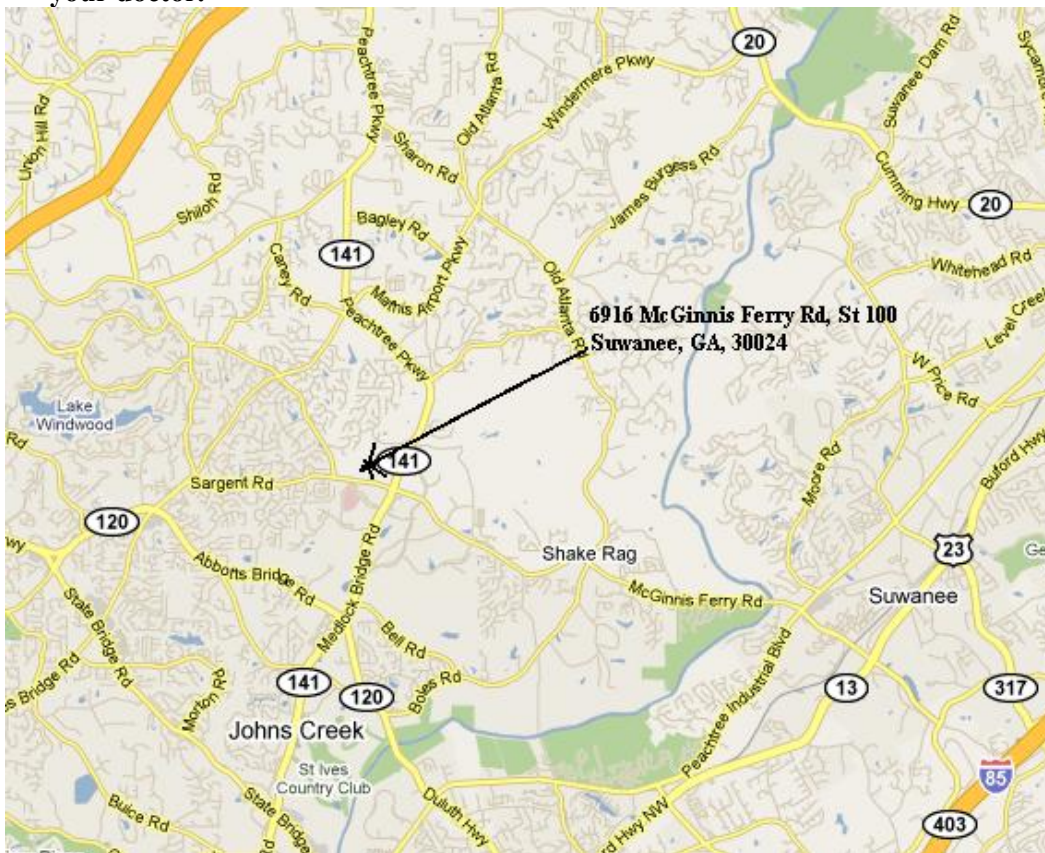
- 0 = would *never* doze or sleep.
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

Name: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Situation</b>	<b>Chance of Dozing or Sleeping</b>
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic	_____
<b>Total score</b>	_____

# Instructions for Sleep Study

1. Bring something loose and comfortable to wear while sleeping (T-Shirt required).
2. Feel free to bring a book or favorite pillow. Each room has a TV if you wish to watch it.
3. Wash and dry your hair on the day of your sleep study. Don't use hair products, such as gels, hairsprays or heavy conditioners, because it will prevent electrodes from sticking on the scalp.
4. Please do not wear makeup.
5. Remove nail polish and or artificial nails from at least two fingers.
6. Bring your own toiletries such as toothpaste, toothbrush, hairbrush, comb etc...
7. Showers are available for use.
8. Bring set of clothes for the following day.
9. Please continue to take any medications that are used on daily basis. This includes sleeping pills. We are not responsible for any medications brought into the center.
10. Please bring any medications that are used on a daily basis.
11. Try to get a normal night's sleep before the test, unless instructed otherwise by your doctor.



Please call at least 24 hours in advance if you need to reschedule.  
Please arrive at the sleep lab at 8:00PM  
6916 McGinnis Ferry Rd, Suite 100, Suwanee, GA, 30024

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**SLEEP STUDY CANCELLATION POLICY**

Please be aware of the current cancellation/No Show policy. Our office will charge \$75 for any sleep study appointment time not kept. Testing must be cancelled or rescheduled at least 48 hours prior to the appointment. Failure to do so will result in the \$75 fee. This fee will not be billed to the insurance company and is the patient's responsibility. Thank you in advance for your cooperation.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **DISCLOSURES**

### **NON-SMOKING POLICY**

Please note that for the health and safety of our patients and employees, we are a non-smoking facility. Patients will not be allowed to smoke inside the facility.

\_\_\_\_\_  
**Patient's Initials**

### **RELEASE OF PERSONAL BELONGINGS**

We are sorry that we cannot be held responsible for your personal belongings. We strongly encourage you to leave all personal items, including wallets, jewelry, cameras, money, etc. I understand that this facility will not be held responsible for any missing articles.

\_\_\_\_\_  
**Patient's Initials**

### **ADVANCE DIRECTIVES**

I understand that advance directives are NOT honored at Sleep Care Solutions; and in the event of a life-threatening situation, emergency medical procedures will be instituted in every instance and patients will be transferred to a higher level of care where the decision to continue or to terminate emergency measures can be made.

\_\_\_\_\_  
**Patient's Initials**

### **SLEEP STUDY PROCEDURE CONSENT**

As a routine part of your sleep study, data sensors will be applied to the body, at various locations including the face, scalp, legs, chest and abdomen. A Positive Airway Pressure interface (mask or nasal pillow inserts) may be applied at the initiation or during the study as part of the therapeutic process. The undersigned acknowledges permission to apply these devices as part of the diagnosis and initiation of treatment. The undersigned is not in any pain, physical or emotional that would prevent me from having this sleep study performed tonight.

\_\_\_\_\_  
**Patient's Initials**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### **VIDEO / PHOTOGRAPHIC CONSENT**

As a routine part of your sleep study, a video record will be made of you during your sleep test. These records will be kept as part of your medical record at our facility and will be subject to the Privacy Policy of The Sleep Institute.

\_\_\_\_\_  
**Patient's Initials**

### **DISCLOSURE OF OWNERSHIP**

The Sleep Institute strives to provide the highest quality of patient care. Your physician may have less than or equal to 5% ownership in The Sleep Institute. An ownership interest in this program enables the physician to have a voice in the administration and medical policy of the health care institution. This involvement helps to ensure the finest quality care for our patients. Florida law requires that we notify you of alternative facilities available to you. These are listed below:

\_\_\_\_\_  
**Patient's Initials**

<b>Sleep Disorders Center of Georgia Ctr Atlanta, GA (404) 257-0080</b>	<b>Northside Hospital Sleep Disorders Atlanta, GA (404) 851-8135</b>
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### **INFORMATION PRIVACY**

The Sleep Institute will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard s to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities and have copies available for distribution. The undersigned acknowledges receipt of this information.

\_\_\_\_\_  
**Patient's Initials**

### **FINANCIAL AGREEMENT**

The undersigned patient or responsible party is responsible for the fees for service. If you have insurance that covers this service, The Sleep Institute will the insurance carrier(s) as a courtesy to you. After 60 days from the Date of Service, the balance is due and payable by the undersigned, unless other financial arrangements were previously made. PLEASE NOTE, you will have two separate charges for this test. One charge will from The Sleep Institute of Nashville and one charge will come from the interpreting physician.

\_\_\_\_\_  
**Patient's Initials**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### **AUTHORIZATION TO RELEASE INFORMATION**

**In order to process a claim for benefits, I authorize The Sleep Institute, or its representative, to release any information regarding my medical history, symptoms, treatment, study results, and diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original.**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

### **AUTHORIZATION TO PAY BENEFITS**

**I hereby authorize payment to The Sleep Institute of benefits paid by my insurance company. Any amount exceeding my indebtedness will be refunded. I understand that I am financially responsible for the fees for service including all non-covered services, co-payments, and deductibles. A photocopy of this authorization shall be considered as effective and valid as the original.**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**