Scheduled Appointment Information

Your physician ordered sleep study has been scheduled as follows:

Date and Time: ___________________________at ______ pm
Location: 3100 SW 89th Street, OKC, OK 73159

We are located on SW 89th Street, between May Ave, and I-44. Please arrive at 8:00 pm at the East Side of the building. Check in through the pain Center. Once you are checked in the technician will arrive to escort you to the sleep disorder center. **PLEASE NOTE THAT A TECHNICIAN WILL NOT ARRIVE UNTIL 8:00PM.**

*** Reminder:** No nap or caffeine after 12 pm the day of your study. Please eat your evening meal at least 2 hours prior to your scheduled test time. Do not consume any Alcohol 24 hours prior to the test.

*** IMPORTANT: You must cancel or reschedule 24 hours before your set appointment or you will be charged a technician fee of $250.00. To receive a refund of the fee, all appointments must be rescheduled within 72 hours of the original scheduled appointment and you must attend the newly scheduled appointment.**

Things to bring:

1. The enclosed questionnaire – (please complete prior to arrival)
2. Something loose fitting and comfortable to sleep in, as well as, a robe and slippers.
3. All medications that you are currently taking - (please have them written down prior to arrival)
4. Your insurance card and two forms of identification including a picture I.D.

Things to remember:

1. Questions regarding your medications should be referred to your physician.
2. Your hair **must** be clean and free of gels and hair spray materials.
3. We have pillows; however, please feel free to bring your own to add to your comfort.
4. Bring an overnight bag with the items you would normally use for an overnight stay.
5. Smoking materials, tobacco, and firearms are prohibited in our facility.

Insurance and Financial Responsibility:

If you have any questions regarding your insurance please feel free to call Community Hospital at **602-8100.** You will be responsible for the actual contracted amount if the claim is not paid in full. We urge you to contact your insurance provider member services to verify the information above.

If you have any questions about this sleep study or any information contained in this letter, please contact us prior to your appointment. Our Patient Care Coordinator will be happy to answer any questions you may have -- (405) 949-0060 M-F 8-5.

SLEEP STUDY MEDICAL HISTORY

Patient Name: ____

Height: ________ Weight: _______ Age: _________

Symptoms of Sleep Disturbances: (check those that apply)

☐ Witnessed apnea	☐ Shortness of breath	☐ Sleep-Walking	☐ chronic fatigue
☐ Post UPP	☐ Nightmares	☐ Asthma	☐ Narcolepsy
☐ Snoring	☐ Obesity	☐ Elongated palate	☐ Cataplexy
☐ Restless legs	☐ Bedwetting	☐ Excessive sleepiness	☐ Insomnia
☐ Nocturnal choking	☐ Nasal obstruction	☐ p.m. alcohol	☐ Claustrophobia
☐ Leg/body jerks	☐ Sleep terrors	☐ Chronic Pain	
☐ Fitful sleep	☐ GI reflux/heartburn	☐ Periodic leg movement	
☐ REM Behavior	☐ Sleep attacks	☐ Frequent awakenings	
☐ Depression	☐ Nightmares	☐ Violent activity during sleep	

Pertinent Medical History: (check those that apply)

☐ High Blood pressure	☐ Head injury	☐ Heart attack
☐ COPD/Emphysema	☐ Neuromuscular disease	☐ Memory loss
☐ s/p stroke	☐ Seizures	☐ Neuromuscular Disease
☐ Cardiovascular disease	☐ Premature birth	☐ Parkinson's Disease
☐ Diabetes	☐ Thyroid disease	☐ Mood disorder
☐ Kidney failure	☐ Broken nose	☐ Fibromyalgia
☐ Cerebral Palsy	☐ Oxygen: LPM____	☐ Other:__________________
☐ Head injury	☐ History of Motor Vehicle Accident	

Surgeries: (check those that apply)

☐tonsils ☐adenoids ☐UPPP ☐deviated septum ☐nasal polyp ☐laser

☐tracheotomy ☐upper or lower ☐jaw reconstruction

Previous Sleep Study:

☐No ☐Yes When and where:____

(If previous sleep study, please include a copy of this report.)

Current Treatment of Sleep Apnea:

☐CPAP Pressure___________ ☐ Bi-Level Pressure___________ ☐Oxygen Liters__________

Medications:____

____

____

*Revised 7/12/2011

SLEEP QUESTIONNAIRE

Patient ID: ________________________ Date of Study: _____________________

NAME: ________________________________ AGE: ________ SEX: _______ Date:__________

REFERRING PHYSICIAN: ____

HT: ______ WT: ______ Neck Size: ______

PLEASE GIVE THE COMPLETED QUESTIONNAIRE TO THE TECHNICIAN AT THE TIME OF YOUR SLEEP STUDY.

MY PRIMARY SLEEP COMPLAINT IS: ____

HOW LONG HAVE YOU HAD THIS PROBLEM? __________________________________

HAVE YOU EVER SEEN A PHYSICIAN FOR THIS PROBLEM? _____________________

HAVE YOU EVER HAD A SLEEP STUDY? ______________________________________

(IF YES, WHEN AND WHERE) ____

DO YOU HAVE ANY OTHER SLEEP PROBLEMS? _______________________________

(IF YES, PLEASE DESCRIBE) ____

DO ANY OF YOUR FAMILY MEMBERS HAVE A SLEEP DISORDER? (IF YES, DESCRIBE)
____

DO YOU USE OXYGEN AT HOME? NO ___ YES ___ 24 HR/DAY ___ NIGHT ONLY ___

MEDICATION NAME	DOSAGE	REASON

****USE THE OTHER SIDE OF THIS PAGE TO LIST ADDITIONAL MEDICATIONS.

LIST YOU INTAKE PER DAY OF THE FOLLOWING:

ITEM	DAILY INTAKE	ITEM	DAILY INTAKE	ITEM	DAILY INTAKE
COFFEE		BEER		CIGARETTES	
CAFFIENE SODA		WINE		CIGARS/PIPE	
TEA		LIQUOR		SNUFF	

WHAT TIME DO YOU GO TO SLEEP? __________WHAT TIME DO YOU WAKE UP?________

HOW LONG DOES IT USUALLY TAKE YOU TO FALL ASLEEP?___________

DO YOU AWAKEN OFTEN DURING THE NIGHT? ______________________

(IF YES, WHY?) ____

DO YOU NAP DURING THE DAY? ___________________________________

(IF YES, DO YOU FEEL REFRESHED UPON AWAKENING?) _____________

DO YOU WORK DIFFERENT SHIFTS? _______________________________

(IF YES, WHAT SHIFT(S) DO YOU WORK?) ___________________________

Name: ______________________________________ Date of Study: _______________

Patient ID: _____________________

Please answer the following questions using this scale: (Consult bed partner)
0=never 1=rarely 2=sometime 3=often 4=frequently 5=always

EXCESSIVE DAYTIME SLEEPINESS:

0 1 2 3 4 5 I FEEL SLEEPY DURING THE DAY.

0 1 2 3 4 5 I SOMETIMES FALL ASLEEP WHEN I DON'T WANT TO.

0 1 2 3 4 5 I FALL ASLEEP WHEN I READ THE NEWSPAPER.

0 1 2 3 4 5 I FALL ASLEEP WHILE WATCHING TV.

0 1 2 3 4 5 I FALL ASLEEP AT WORK.

0 1 2 3 4 5 I FALL ASLEEP AT MEETINGS.

0 1 2 3 4 5 I HAVE FALLEN ASLEEP WHILE DRIVING.

0 1 2 3 4 5 I GET SLEEPY WHILE DRIVING.

0 1 2 3 4 5 I HAVE PROBLEMS WITH MY PERFORMANCE AT WORK BECAUSE OF FATIGUE AND TIREDNESS.

0 1 2 3 4 5 I DON’T FEEL REFRESHED WHEN I AWAKEN.

0 1 2 3 4 5 I HAVE TO TAKE NAPS DURING THE DAY.

0 1 2 3 4 5 I GET SLEEPY WHEN I AM INACTIVE.

0 1 2 3 4 5 I HAVE TO PUSH MYSELF TO GET THINGS DONE.

0 1 2 3 4 5 I HAD TROUBLE STAYING AWAKE DURING THE DAY AS A CHILD.

SLEEP APNEA:

0 1 2 3 4 5 I HAVE BEEN TOLD THAT I SNORE.

0 1 2 3 4 5 OTHERS CAN’T SLEEP IN THE SAME ROOM BECAUSE I SNORE.

0 1 2 3 4 5 I HAVE BEEN TOLD I STOP BREATHING WHILE ASLEEP.

0 1 2 3 4 5 I AWAKEN WITH HEADACHES.

0 1 2 3 4 5 I AM OVERWEIGHT OR AM GAINING WEIGHT.

0 1 2 3 4 5 I PERSPIRE AT NIGHT.

0 1 2 3 4 5 I HAVE BEEN TOLD I’M A RESTLESS SLEEPER.

0 1 2 3 4 5 I HAVE AWAKENED DURING THE NIGHT CHOKING.

0 1 2 3 4 5 I FEEL SLEEPY DURING THE DAY EVEN THOUGH I SLEPT ALL NIGHT.

0 1 2 3 4 5 I HAVE ASTHMA ATTACKS DURING SLEEP

Name: ___________________________________ Date of Study: _______________

Patient ID: ____________________________

RESTLESS LEG SYNDROME OR NOCTURNAL MYOCLONUS:

0 1 2 3 4 5 I HAVE MUSCLE TENSION IN MY LEGS EVEN WHEN I'M RELAXED.

0 1 2 3 4 5 I HAVE BEEN TOLD PARTS OF MY BODY "JERK" AT NIGHT.

0 1 2 3 4 5 I HAVE BEEN TOLD I KICK DURING THE NIGHT.

0 1 2 3 4 5 I HAVE ACHING OR "CRAWLING" SENSATIONS IN MY LEGS.

0 1 2 3 4 5 I EXPERIENCE LEG PAIN DURING THE NIGHT.

0 1 2 3 4 5 SOMETIMES I CAN'T KEEP MY LEGS STILL AT NIGHT.

INSOMNIA:

0 1 2 3 4 5 I HAVE TROUBLE GETTING TO SLEEP AT NIGHT.

0 1 2 3 4 5 I HAVE TROUBLE STAYING ASLEEP AT NIGHT.

0 1 2 3 4 5 I AWAKEN IN THE MORNING LONG BEFORE I WANT TO.

0 1 2 3 4 5 I WORRY I WILL BE UNABLE TO SLEEP.

0 1 2 3 4 5 I AWAKEN WITH FEELINGS OF ANXIETY OR FEAR.

SLEEP BEHAVIOR:

0 1 2 3 4 5 I HAVE BEEN TOLD I WALK IN MY SLEEP.

0 1 2 3 4 5 I HAVE BEEN TOLD I TALK IN MY SLEEP.

0 1 2 3 4 5 AS AN ADULT, I HAVE WET THE BED.

0 1 2 3 4 5 WHEN I LAUGH OR GET ANGRY, I FEEL LIKE I'M GOING LIMP.

0 1 2 3 4 5 I HAVE FALLEN ASLEEP WHILE LAUGHING OR CRYING.

0 1 2 3 4 5 I HAVE VIVID DREAM-LIKE SCENES UPON FALLING ASLEEP.

0 1 2 3 4 5 I FEEL LIKE I WALK AROUND IN A DAZE.

0 1 2 3 4 5 SOMETIME I CAN'T TELL DREAMS FROM REALITY.

0 1 2 3 4 5 I AWAKEN DURING THE NIGHT WITH HEARTBURN.

0 1 2 3 4 5 I HAVE BEEN TOLD THAT I ACT OUT MY DREAMS.

0 1 2 3 4 5 I HAVE NOW OR IN THE PAST HAD SEIZURES IN MY SLEEP.
WHEN ________

LIST ANY PAST/PRESENT MEDICAL OR PSYCHAITRIC PROBLEMS. LIST ANY OTHER CONCERNS YOU HAVE ABOUT YOUR SLEEP.

____

____

____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Epworth Sleepiness Scale

Patient: ____ **Date:** ______________

The instrument

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.

Use the following scale to choose the most appropriate number for each situation:

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

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

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Patient Information:

Patient Name: ____ DOB: ________Age: ______________

Address: ________________________________ City: ____________________ Zip: ______________

Home Phone: ________________ Work:______________________ Cell: ______________________

Ht______ LBS__________ Referring Physician__________________________________

Primary Care Physician_______________________ Phone Number ________________

SS#: ___________________________________ Gender: ☐ Male ☐ Female

Marital Status ☐S ☐M ☐D ☐W

Email address: __________________________________

Insurance Information: **Please provide our office with a copy of your insurance card.**

Primary Insurance Carrier:_________________________ Phone: __________________________

ID #: ________________________________ Policy Group #: ________________________________

Policy Holder: __________________________________ Relationship to Patient: __________________

Policy Holder's Date of Birth: _____________________ Policy Holder's SS#: ____________________

Secondary Insurance Carrier:_______________________ Phone: __________________________

ID #: ________________________________ Policy Group #: ________________________________

Policy Holder: __________________________________ Relationship to Patient: __________________

Policy Holder's Date of Birth: _____________________ Policy Holder's SS#: ____________________

Employment Information:

Employer________________________________ Work Ph#: _______________________

If the patient is a minor, please list guardian information:

Guardian: _______________________________ Phone #: _________________________

Third Party Billing:

Is your injury work related?	☐**Yes**	☐**No**
Is this injury due to an accident?	☐**Yes**	☐**No**
If your injury is MVA related, have you obtained an accident report?	☐**Yes**	☐**No**

Injury date or Date of Occurrence:_____________________________.

Emergency Contact:

Name: _______________________________________ Relationship: _____________________

Phone: ____________________________________

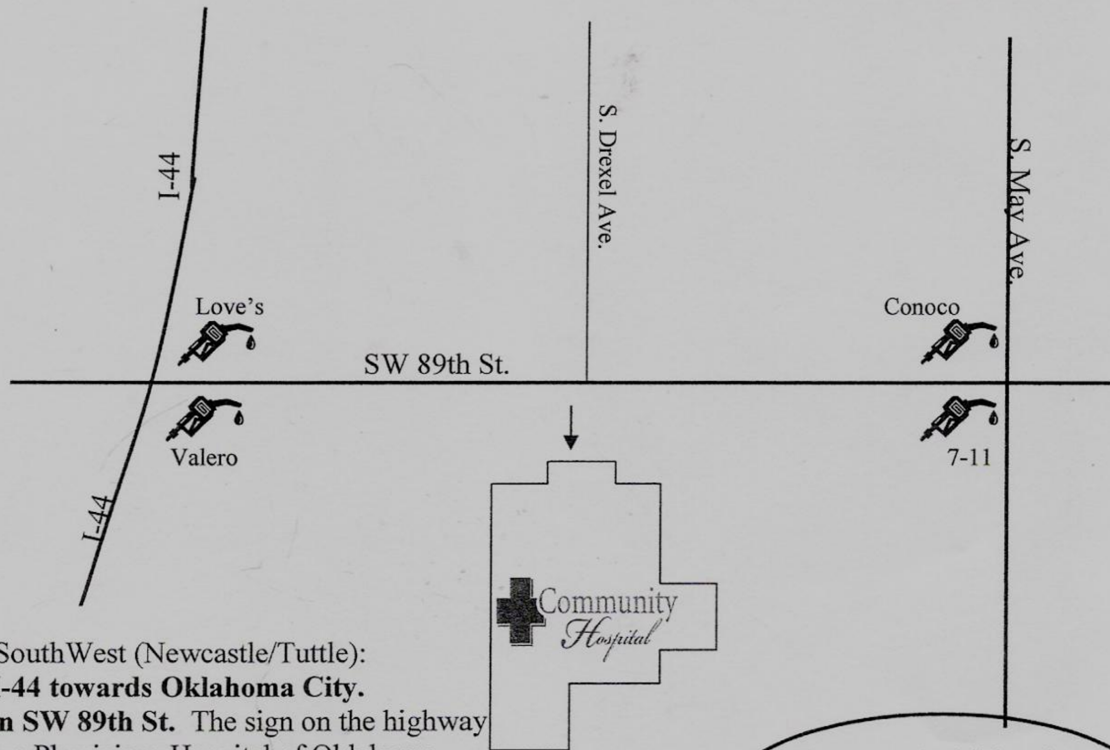
☐ I would like to receive a copy of my final study mailed to my address provided.

Signature: ____ Date: __________________

Directions to Community Hospital (formerly Physicians Hospital).

3100 SW 89th St, Enter through the North Doors.

We are on SW 89th between May and I-44.



If you need additional directions or you are lost, please call (405)949-0060

From the SouthWest (Newcastle/Tuttle):

1. Take **I-44 towards Oklahoma City.**
2. **Exit on SW 89th St.** The sign on the highway still says Physicians Hospital of Oklahoma.
3. Turn **Right onto SW 89th**, going East.
4. Turn **Right into Community Hospital**, you will go left at the Front entrance towards the Physical Therapy entrance on the East side.

From the NorthWest (Bethany/Yukon/NW OKC):

1. Take **I-44 towards Lawton**, going south. From Yukon take I-40 to I-44.
2. **Exit on SW 89th St.** The sign on the highway still says Physicians Hospital of Oklahoma.
3. Turn **Left onto SW 89th**, going East.
4. Turn **Right into Community Hospital**, you will go left at the Front entrance towards the Physical Therapy entrance on the East side.

From South OKC:

1. Take **May Ave north** towards OKC.
2. Turn **left onto SW 89th**, going west.
3. Turn **left into Community Hospital**, you will go left at the Front entrance towards the Physical Therapy entrance on the East side.

From the SouthEast (Moore/Norman):

1. Take **89th St, going west**. If farther south, take **I-35 to the SE 89th St. exit** and turn left onto 89th.
2. Take **89th west until you cross May Ave**.
3. Turn **left into Community Hospital**, you will go left at the Front entrance towards the Physical Therapy entrance on the East side.

1. From the NorthEast (Del City/Midwest City, other points on north I-35):
2. Take **I-240 going west** towards OKC or take I-35 southbound to I-240 west.
3. **Exit on May Ave.** and turn left, going south.
4. Turn **Right onto SW 89th.**
5. Turn **left into Community Hospital**, you will go left at the Front entrance towards the Physi-