Sleep Solutions

Scheduled Appointment Information

Your physician ordered sleep study has been scheduled as follows:

Date and Time: _____@8:30 pm –

Location: 13920 North Western Avenue; Edmond, OK 73013

Web Site: www.sleepsolutionsllc.net

Our sleep lab has been designed with your comfort in mind. The atmosphere is warm and inviting, very similar to a nice, quality hotel room. We offer the conveniences of a flat screen television (w/DVD), and reading materials. Our primary goal is to create an environment that will assist in getting a "normal" night's sleep.

Please note that a technician will not arrive until 8:30 PM.

IMPORTANT: **Patients who require assistance from a caregiver must have the caregiver present at all times. CAREGIVERS will be required to stay with the patient for the duration of the study.**

* Reminder: No nap or caffeine after 12 pm the day of your study. Please eat dinner before you come.

*** 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.**

Please ring the doorbell for admittance into the lab.

Things to bring with you:

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. Please take all of your medications as you normally do. If you use a sleep aide, we ask that you bring it with you and inform the technician before you take it.
3. Your hair **must** be clean and free of gels and hair spray materials.
4. We have pillows; however, please feel free to bring your own to add to your comfort.
5. Bring an overnight bag with the items you would normally use for an overnight stay.
6. Smoking materials, tobacco, and firearms are prohibited in our facility.

Please note that the amount you have been quoted to pay is an estimation of benefits based on the information provided to us by your insurance company. This information cannot be relied upon as a final agreement of financial responsibility. Some charges may differ depending on your insurance plan and the processing of charges. If you have any questions please contact your insurance company or our office for further clarification.

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 met more of your deductible please contact our office with this so we can call your insurance company. This could considerably change your cost.

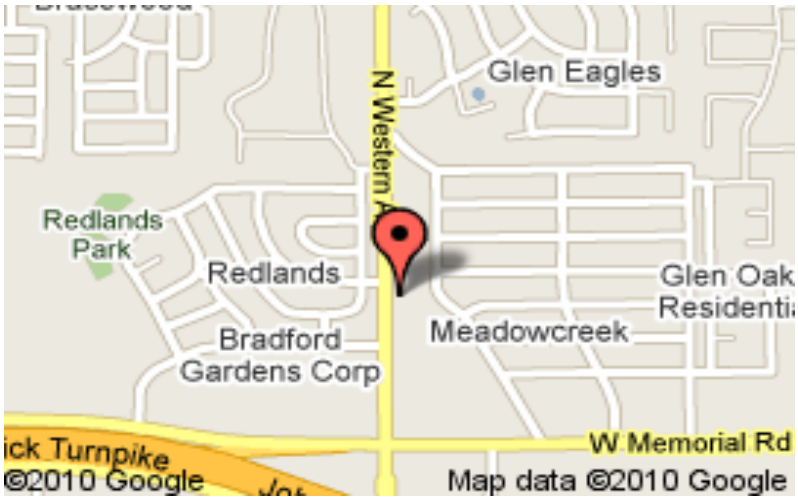
We accept VISA, MasterCard, Discover, and checks. **NO CASH PLEASE.**

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 8:30-5:00.

After Hours, please call 405-600-1241.

13920 North Western Avenue,
Edmond, OK 73013

We are located on Western Ave, approximately ½ mile north of Memorial Road. Our sleep lab is located on the East side of the road across from the Redlands housing addition.



For assistance after hours, please contact a technician at 405-600-1241.

Sleep Solutions

PLACE LABEL HERE

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 Solutions

PLACE
LABEL
HERE

SLEEP QUESTIONNAIRE

Patient Name: _____ Date: _____

Date of Birth: _____ Sex: (circle one) M F Height: _____ Weight: _____

Referring Physician: _____ Primary Care Physician: _____

Welcome to our sleep clinic. The following questions will help us understand more about you and your possible symptoms. Please answer the questions as frankly and accurately as possible as they relate to the last 12 months. Do not leave any question unanswered.

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Main Complaint (Please describe): _____

How long have you had this problem? About _____ years

Have you ever seen a physician for this problem? Yes __ No ___

Have you ever had a sleep study before? Yes ___ No ___

If yes, when and where: _____

Do you have a CPAP or BiPAP machine? Yes ___ No ___ How much do you use the machine? _____

Do you use O_2 at home? Yes ___ No ___ Night Time O_2 use: Yes ___ No ___

What is your normal bedtime? (When you try to go to sleep, although you may not actually fall asleep until later)
_____

How long does it usually take you to fall asleep? _____

Do you awaken often during the night? Yes ___ No ___ How many times: _____
If yes, why? _____

What time do you get up in the morning? _____ Do you feel refreshed? _____

Do you usually nap during the day? Yes ___ No ___

Do you work different shifts? Yes ___ No ___ What shift? _____

Circle the appropriate responses

I have high blood pressure:	Yes / No	I have diabetes:	Yes / No
I have an irregular heartbeat:	Yes / No	I have asthma:	Yes / No
I have had a stroke or TIA:	Yes / No	I have heartburn at night:	Yes / No
I have history of congestive heart failure:	Yes / No	I have seizures:	Yes / No
I have had a heart attack:	Yes / No	I have COPD:	Yes / No

Sleep Solutions

PLACE
LABEL
HERE

Please answer the following questions using this scale (consult bed partner):
0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Frequently 5 = Always

0 1 2 3 4 5 I have been told that I snore.

0 1 2 3 4 5 Others cannot sleep in the same room because I snore loudly.

0 1 2 3 4 5 I have been told that I stop breathing while asleep.

0 1 2 3 4 5 I do not 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 have problems with my performance at work because of fatigue and tiredness.

0 1 2 3 4 5 I sometimes fall asleep at inappropriate times.

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 awaken with headaches.

0 1 2 3 4 5 I sweat at night.

0 1 2 3 4 5 I have awakened during the night choking.

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 have been told I kick during my sleep.

0 1 2 3 4 5 I have an aching or crawling sensation in my legs in the evening.

0 1 2 3 4 5 The aching or crawling sensation in my legs worsens if I keep my legs still.

0 1 2 3 4 5 The unpleasant sensations in my legs improve with activity.

0 1 2 3 4 5 I eat in my sleep.

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 When I laugh or get angry, I feel like I am going limp. (getting weak)

0 1 2 3 4 5 When I am falling asleep or awakening, I am paralyzed and unable to move.

0 1 2 3 4 5 I have vivid dreams or hallucinations as I go to sleep or wake up.

0 1 2 3 4 5 I have been told I act out my dreams.

0 1 2 3 4 5 I have nightmares.

Sleep Solutions

PLACE
LABEL
HERE

How much caffeine do you consume daily? Coffee (cups) _____ Cola/Tea: _____

Do you drink caffeine in the evening? Yes ___ No __ Do you drink alcohol before bedtime? Yes ___ No ___
Kind and Amount: _____

Serious Medical Problems and Surgeries (with dates)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List all medications you are currently using:

Name of Medication	Dose & Frequency	Last time medication was taken?	Name of Medication	Dose & Frequency	Last time medication was taken

PLACE
LABEL
HERE

Sleep Solutions

Name: _____
Date: _____

EPWORTH SLEEPINESS SCALE

How likely are you to fall asleep or doze in the circumstances listed below? When rating these situations, give the highest consideration to recent events. If you have never experienced one of these situations, estimate how you might have reacted.

0 = no chance

1 = slight chance
2 = moderate chance
3 = high chance

SITUATION:

Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (i.e. theater or 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 quietly to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
TOTAL:	**_____**