900 N. Montana Avenue Suite A9 Helena, MT 59601 (406) 449-8999 Fax (406) 449-8989
400 W. Granite, Butte MT. 59701 (406) 782-4595 Fax (406) 782-4355

Please complete all other paperwork and return in envelope provided, fax it back to us, or bring with you.
(12 HOURS NOTICE IS REQUIRED TO AVOID A $100.00 CANCELLATION FEE)
****If you are coming due to excessive sleepiness please have someone drive you and pick you up* **

YOU WILL NEED TO PROVIDE A COPY OF YOUR INSURANCE CARD. THANK YOU.

Dear Patient:

ON THE DAY OF YOUR SLEEP STUDY:

1. Eat meals as usual, but don't drink alcohol or caffeinated drinks (such as coffee, cola or tea) after 12:00 noon.
2. Please make certain that your hair is DRY. Do not use hair oils such as VO5 or Brillo Cream.
3. Please perform nighttime routine at home: Brush your teeth, Wash your face etc. Do not apply any lotion to your face or legs.
4. Take your medications as instructed by your physician.
5. Do not take any naps if possible.
6. For men: If you have a beard please consider shaving before coming in. (It is best to have a shaved chin if possible☺) If you do not wish to have a shaved chin, please leave your beard a bit longer rather than short and stubbly. A goatee style works nicely.

WHAT TO BRING:

1. Bring nightwear to sleep in, (should be 2-piece, cotton is best,.) (t-shirt and shorts are ideal)
2. Bring any medications that you may need to take in the evening, including any sleep aids you might have.
3. Bring any diabetic glucose testing with you in the event you should need to test.
4. Important: If you usually have a snack before bed, please bring it with you. Refrigerator and microwave are available.

Please notify us by phone as soon as possible if you can not make your appointment.

What is a sleep study?

A sleep study is an all-night study designed to provide vital information about your sleeping health by monitoring various signals from your body. These signals include: brain-waves, heart activity, muscle activity, eye movements, breathing patterns and oxygen levels. The signals are obtained from small sensors attached to you scalp, face and body. No needles are used and you should not experience any unusual discomfort. Sleep studies enable physicians to evaluate conditions which occur only during sleep and are non-detectable during a regular office exam. Sleep studies help to identify causes of various sleep-related health disorders and to plan for effective treatment.

What is the procedure during a sleep study?

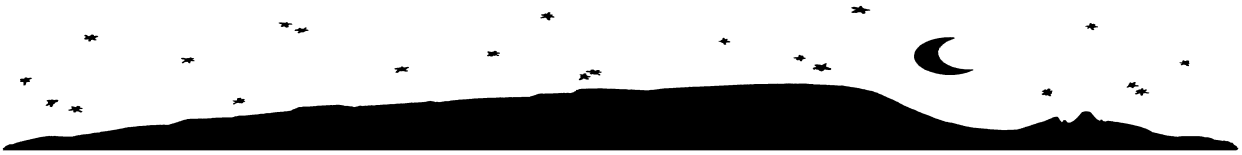
It will take a sleep technologist about 45 minutes to attach small sensors to your head, chest stomach and legs. During the night you will be monitored and attended by the technologist from an adjoining room.

What is the procedure after a sleep study?

It will take approximately 7-9 working days for the study results to get back to your primary care physician. He/She will contact you concerning the results.

BILLING PROCEDURE: There are two parts to a sleep diagnostic testing bill. The technical component is what is performed on the night of your sleep study. A board certified sleep specialist will bill the professional component of the sleep study for his/her interpretation report. (Just like when you have an x-ray. You get a separate bill from the radiologist)

**Please complete paperwork and fax back, mail back in envelope provided, or bring with you. Thank you.



SLEEP DIAGNOSTICS, INC.

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Sleep Screening Questionnaire

PLEASE PRINT YOUR NAME *EXACTLY* AS IT APPEARS ON YOUR INSURANCE CARD.

*Name :(Last, First)*_____ *Mrs.* _____*Mr.* ._____*Ms.*_____

Address: _____ City: _____ State: _____Zip:_____

Telephone: (home) _____ (work) _____ (other) _____

Social Security #_____ Birthdate: _____ Sex: M F Wt: _____lbs. Ht: _____in.

Employer _____

Insurance.#1_____ID#_____ Group #_____

Policy holder's name and date of birth _____ Birthdate_____

Insurance.#2_____ID#_____ Group #_____

Policy holder's name and date of birth _____ Birthdate_____

List ALL medications and sleep aids:

BE SURE TO LIST OXYGEN IF YOU USE IT AND YOUR OXYGEN COMPANY

MEDICATON	DOSE	MEDICATION	DOSE

Briefly describe your sleep problem. If you do not feel that you have a sleep problem, please describe why you believe your doctor has ordered this test and complete the questionnaire regardless of whether or not you feel you have a problem. _____

_____

_____

My weight 1 year ago was about_____ pounds.
( ) I have had a recent weight gain in past 6 months
( ) I have had a recent weigh loss in past 6 months

My weight 10 years ago was about_____ pounds.
How much? _____ pounds
How much? _____ pounds

I walk independently without assistance…… YES NO
I use a cane to walk……. YES NO
I use a walker to assist me with walking…… YES NO
I use a wheelchair……. YES NO
I need assistance getting in and out of bed……YES NO
I sleep with more than one pillow……. YES NO
If yes why and where is it located?_____
I sleep in a recliner……. YES NO
If yes why? _____
I sleep in a hospital bed……. YES NO
If yes why? _____

I have a hearing problem……. YES NO
If yes, do you wear a hearing aid? YES NO
I wear dentures……. YES NO
If yes, do you wear them at night? YES NO
I wear oxygen at night……... YES NO
If yes, how much flow? _____
I wear oxygen during the day…….. YES NO
If yes, how much flow? _____
I already wear a CPAP or BiPAP machine for sleep apnea……YES NO
If yes, what are your settings? _____ List the company that provides your CPAP_____

The following questions relate to your normal bedtime habits or routines.

1. My normal bedtime is_____
2. I usually get up for the day at_____
3. My bedtime varies on weekends between _____and_____
4. I drink beverages with caffeine within 2 hours of bedtime? YES NO If yes, ___ days/week on avg?
5. I drink alcohol within 2 hours of bedtime? YES NO If yes, ____days/week on avg?
6. I use tobacco (smoke/chew) within 2 hrs before bedtime? YES NO If yes, ___ days/week on avg?
7. I exercise within 2 hours before bedtime? YES NO If yes, ___ days/week on avg?
8. It usually takes me this long to fall asleep at night _____min
9. I usually get up to the bathroom this many times a night_____
10. The times I am usually awake in the night are_____, _____, _____
11. I take medications to help me sleep this many times a week_____
12. During the night I am awake for this long? _____min

Please indicate how many of each of the following do you consume PER DAY?
Coffee (with caffeine) _____6 oz cups
Tea (with caffeine) _____ 12 oz glasses
Colas or other beverages containing caffeine _____12 oz glasses or bottles
Chocolate _____oz
Beer _____12 oz bottles, cans, glasses
Hard Liquor _____oz Wine _____ 6 oz glasses
Cigarettes_____ Cigars_____ Chewing Tobacco _____
Water _____ 8 oz glasses

Smoking History
Years Smoked? _____ Avg. packs/ day_____ Have you quit? Yes____ No ____ What year?_____

Please check all that apply and circle frequency

( ) I am a "light sleeper" / "deep sleeper" *please circle one*

( ) I am a "Morning Lark" / "Night Owl" *please circle one*

( ) I feel most "energetic" in the morning / evening *please circle one*

( ) I have allergy problems occasionally / frequently / rarely *circle one*

( ) I have sinus problems occasionally / frequently / rarely *circle one*

( ) I have trouble breathing though my nose in the daytime

( ) I have been told I have a deviated septum

( ) I breathe through my mouth most of the time

( ) I wake up with a dry mouth occasionally / frequently / rarely *circle one*

( ) I have had my tonsils removed

( ) I take medications to help me sleep occasionally / frequently / rarely *circle one*

( ) I have an irregular sleep schedule

( ) I am a shift worker ____evenings ____ night's ____ rotate

( ) I have fallen asleep while driving. (Explain situations and frequency)_____

_____

( ) I pull over to nap while driving to avoid falling asleep: occasionally / frequently / rarely *circle one*

( ) I have had a motor accident due to falling asleep while driving

( ) I do not feel "safe" in my bedroom

( ) Pets in my home disturb my sleep I have this many pets: _____Types of pets: _____

My pets sleep in the bedroom YES NO

( ) My sleep is disturbed by caring for other people (child/family member)

( ) My job is affected by my sleep problem

( ) My spouse or significant other sleeps in the other room because of my sleep problem

( ) I smoke or use tobacco while awake at night

( ) I awaken in the night to eat or drink

( ) I have vivid dreams occasionally / frequently / rarely *circle one*

( ) I have nightmares occasionally / frequently / rarely *circle one*

( ) I have been told that I grind my teeth at night

( ) As an adult, I wet the bed occasionally / frequently / rarely *circle one*

( ) I wake in the night with heartburn or a sour taste in my mouth occasionally / frequently / rarely *circle one*

( ) I awaken with night sweats occasionally / frequently / rarely *circle one*

( ) I awaken with a shortness of breath occasionally / frequently / rarely *circle one*

( ) I awaken with my heart racing occasionally / frequently / rarely *circle one*

( ) I awaken gasping for air occasionally / frequently / rarely *circle one*

( ) I awaken with a headache occasionally / frequently / rarely *circle one*

( ) I awaken with pain occasionally / frequently / rarely *circle one*

If you have any of the following symptoms, please indicate how long you have had the problem:

Check Symptom: **How Long have you had this problem?**

- ☐ Insomnia (difficulty falling asleep or staying asleep)……._____
- ☐ Restless Sleep…….. _____
- ☐ Non- restorative (awaking unrefreshed)…… ._____
- ☐ Frequent Nighttime awakenings…….. _____
- ☐ Sleepiness during the day…….. _____
- ☐ Snoring…….. _____
- ☐ Sleep Apnea (pauses in breathing during sleep)……. _____
- ☐ Restless Legs (uncomfortable crawling, aching sensations)_____
- ☐ Nighttime leg cramps…….. _____
- ☐ Nightmares…….._____
- ☐ Sleepwalking……._____
- ☐ Acting out dreams (punching or striking out while dreaming)_____

On the scale below, please estimate the severity of your sleep problem(s): *circle one*

Mildly Upsetting Moderately Upsetting Very Severe Extremely Severe Totally Incapacitating

Do you want help with your sleep problem? ..... YES NO

If you are diagnosed with Obstructive Sleep Apnea would you be willing to wear a Continuous Positive Airway Pressure (CPAP) mask at night? …….YES NO

Do you wear oxygen currently? ----------YES NO
If yes: What are your settings? _____ **Who is your O2 company?** _____

Are you claustrophobic? …….. YES NO

Do any of your family members have sleep problems or have they been diagnosed with a sleep disorder?..... YES NO
If yes, what disorder? _____

Have you had any other sleep testing performed before? ……. YES NO
If yes, please indicate when and where:

TEST	**LOCATION & MONTH/ YEAR**	**RESULTS**
_____	_____	_____
_____	_____	_____

Please use this space to add any pertinent disease information, such as cardiac (heart), diabetes, pulmonary (lungs), seizures, or any special needs you might have, such as incontinence (Urostomy? or Colostomy?) _____

_____

_____

List any allergies you have include environmental, tape, food, medication and metals:

_____

( ) My insomnia is related to “stress”
( ) I feel depressed----------frequently / occasionally / rarely *(circle one)*
( ) My depression is worse when my insomnia is worse
( ) I feel anxious----------frequently / occasionally / rarely *(circle one)*
( ) My anxiety is worse when my insomnia is worse
( ) My insomnia is related to pain
( ) My pain is worse when my insomnia is worse
( ) I feel muscle tension at night----------frequently / occasionally / rarely *(circle one)*
( ) My mind races while trying to fall asleep
( ) I sleep better in new or unfamiliar places
( ) I sleep worse in new or unfamiliar places
( ) I read, work, or watch T.V. in bed----------frequently / occasionally / rarely *(circle one)*
( ) My sleep is often disturbed by light or noise
( ) My sleep is often disturbed by uncomfortable temperature, hot or cold

---

( ) Uncomfortable feelings in my legs are briefly relieved by moving them or getting up to walk around
( ) Uncomfortable sensations in my legs keep me awake---frequently / occasionally / rarely *(circle one)*
( ) I have nighttime leg cramps----------frequently / occasionally / rarely *(circle one)*
( ) I have been told I move a lot when I sleep----------frequently / occasionally / rarely *(circle one)*
( ) My movements interfere with the sleep of others----------frequently / occasionally / rarely *(circle one)*

( ) I sleep on my back----------frequently / occasionally / rarely *(circle one)*
( ) I never sleep on my back
( ) I take intentional naps
How often? _____per/day This many days per week_____
I nap for this long _____ hours _____ minutes
( ) When I awaken from napping, I feel refreshed
( ) I usually dream when I take a daytime nap

( ) I have hallucinations as I am falling asleep or waking up.-frequently / occasionally / rarely *(circle one)*
( ) I have felt paralyzed upon waking up or falling asleep-----frequently / occasionally / rarely *(circle one)*

( ) I have episodes of muscle weakness or numbness at times of emotional intensity. ie: laughing really hard or crying very hard.
If you checked the above statement, please describe these episodes <u>in complete detail</u>.

_____

_____

_____

_____

_____

_____

SLEEP DIAGNOSTICS, INC.

Epworth Sleepiness Scale

Name: _____ **Date:** _____

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. Using the following scale:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Circle **the most appropriate number for each situation:**

Situation:	***Chance of Dozing***
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive, in a public place such as a 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 a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3

Add all numbers circled together for a Total Amount here: _____

Thank you for your cooperation!

SLEEP DIAGNOSTICS, INC
BED PARTNER SURVEY

Please have a spouse, family member, or someone who has observed you sleeping, complete this page
Patient Name_____
Name of Observer _____
Briefly describe the individual's sleep problems. How long have you noticed these sleep problems? How often do they occur? _____
_____
_____.

1. Does he/she snore when sleeping? ( ) YES ( ) NO

   A. If yes, Does he/she snore Loudly Quietly (please circle one)

   Periodically Continuously (please circle one)

   Infrequently Most nights Every night (please circle one)

2. Does he /she kick often at night? ( ) YES ( ) NO

3. Does he/she have trouble falling asleep at night? ( ) YES ( ) NO

4. Does he/she fall asleep involuntarily during the day? ( ) YES ( ) NO

   A. If yes, please explain_____

5. Is it hard to awaken him/her in the morning? ( ) YES ( ) NO

6. Does he/she awaken frequently in the night? ( ) YES ( ) NO

   A. If yes,

      1. Does he/she awake with a loud snort, gasp or body jerk? ( ) YES ( ) NO

      2. Does he/she have trouble falling back asleep? ( ) YES ( ) NO

      3. Does he/she wake up more often during:

         ( ) early part of night ( ) late part of night ( ) no special time

7. Does he/she appear to stop breathing at night? ( ) YES ( ) NO

   A. If yes,

      1. Does it appear to be related to any one body position? ( ) YES ( ) NO

         If yes, Which position?_____

SLEEP DIARY

NAME ____ **WEEK OF**______________________

Date	Time to Bed Time Awake	Actual number of hours slept	Quality of Sleep	Level of Daytime Sleepiness
			GREAT GOOD FAIR POOR BAD	1 ALERT 2 3 4 5 6 7 VERY SLEEPY
			GREAT GOOD FAIR POOR BAD	1 ALERT 2 3 4 5 6 7 VERY SLEEPY
			GREAT GOOD FAIR POOR BAD	1 ALERT 2 3 4 5 6 7 VERY SLEEPY
			GREAT GOOD FAIR POOR BAD	1 ALERT 2 3 4 5 6 7 VERY SLEEPY
			GREAT GOOD FAIR POOR BAD	1 ALERT 2 3 4 5 6 7 VERY SLEEPY
			GREAT GOOD FAIR POOR BAD	1 ALERT 2 3 4 5 6 7 VERY SLEEPY
			GREAT GOOD FAIR POOR BAD	1 ALERT 2 3 4 5 6 7 VERY SLEEPY

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your care and treatment. As a courtesy we will bill your insurance.

Your insurance policy is a contract between you and your insurance company. Some of our services provided may be non-covered services and not considered necessary under Medicare or other insurance companies. We suggest that you call your insurance carrier if you have any concerns or questions regarding your particular coverage.

Any amount your insurance company does not cover is your responsibility. I acknowledge that lack of payment to my account may result in being turned over to a collections agency and subject to a 40% collector's fee, including all legal cost incurred to collect fees.

I have read and understand this Financial Policy.

_____ _____

Signature of Patient or Responsible Party *Date*

_____

Print Name

Due to HIPPA regulations, we are unable to talk to anyone but the patient regarding their financial account without a signed release. If you would like us to talk with anyone regarding your account, please list his or her name(s) and sign the form below.

I hereby authorize_____
to speak with the staff of Sleep Diagnostics, Inc regarding my financial account. I understand that if I want to change this release, I must do so in writing.

_____ _____

Signature of Patient or Responsible Party *Date*