Pulmonary Associates of Stamford

Sleep Consultation Form

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Name: **Age:** **Sex:** **Primary MD:** **Consult Req from:**

History of Present Illness Date:

Questions	Yes/No or best guess	Doctor's Comments Only
1. Are you tired during the day?		
2. Have you noticed a decreased ability to concentrate?		
3. Do you get sleepy driving?		
4. Is your sleep refreshing?		
5. Do you snore?		
6. Do you ever have a choking feeling at night?		
7. Has anyone said you stop breathing at night?		
8. Do you have leg or arm discomfort at night?		
9. Do you move a lot while sleeping?		
10. Do you get sudden weakness during emotional moments?		
11. Do you have hallucinations when going to sleep or waking up?		
12. Do you ever feel paralyzed when you go to sleep or wake up?		
13. How many caffeinated beverages do you drink a day?		
14. What time is your last caffeinated beverage?		
15. How many alcoholic beverages do you drink a day?		
16. What time is your last alcoholic beverage?		
17. Did you ever smoke?		
18. If you smoke when is your last cigarette?		
19. Do you exercise regularly?		
20. On workdays what time do you: Go to bed Get out of bed		
21. On non-workdays what time do you: Go to bed Get out of bed		
22. How long does it take you to fall asleep at bedtime?		
23. How many times do you wake at night?		
24. How long do you stay awake each time you get up at night?		
25. Do you take naps? If yes what times and how long?		
26. In a 24-hr period how many hours do you spend in bed?		
27. In a 24-hr period what is your average amount of sleep?		
28. Is your bedroom quiet and comfortable?		
29. Is your bedroom clock lit?		
30. Do you need an alarm clock to wake up?		

31. Do you have a TV, radio or computer in your bedroom?		
32. Have you ever had a sleep study?		
33. Have you ever been treated for a sleep problem?		
34. How long have you had your sleep problem?		

Please list some of the things you have tried to treat your difficulty sleeping:

BDI-PC

This questionnaire consists of 7 groups of statements. Read each group of statements; then pick out the **one statement** that best decribes the way you felt in the **past two weeks, including today.** Circle the number beside th statement you picked. If more than one statement applies, circle the highest one.

SADNESS	I do not feel sad	0
	I feel sad much of the time	1
	I feel sad all of the time	2
	I am so sad I can't stand it	3
PESSIMISM	I am not discouraged about my future	0
	I feel more discouraged about my future than I used to be	1
	I do not expect things to work out for me	2
	I feel my future is hopeless and will get worse	3
PAST FAILURE	I do not feel like a failure	0
	I have failed more than I should have	1
	As I look back, I see a lot of failures	2
	I feel I am a total failure as a person	3
SELF-DISLIKE	I feel the same about myself as ever	0
	I have lost confidence in myself	1
	I am disappointed in myself	2
	I dislike myself	3
SELF-CRITICISM	I don't criticize or blame myself more than usual	0
	I am more critical of myself than I used to be	1
	I criticize myself for all my faults	2
	I blame myself for everything bad that happens	3
SUICIDAL IDEAS	I don't have any thoughts of killing myself	0
	I have thoughts of killing myself, but I won't do it	1
	I would like to kill myself	2
	I would kill myself if I had the chance	3
LOSS OF INTEREST	I have not lost interest in other people or activities	0
	I am less interested in other people or things than before	1
	I have lost most of my interest in other people or things	2
	It's hard to get interested in anything	3

The Epworth Sleepiness Scale

NAME: _____ ***DATE:*** _____

Height: _____ **Weight:** _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 = WOULD NEVER DOZE 1 = SLIGHT CHANCE OF DOZING 2 = MODERATE CHANCE 3 = HIGH CHANCE OF DOZING

SITUATION	CHANCE OF DOZING
SITTING AND READING	_____
WATCHING TV	_____
SITTING INACTIVE IN A PUBLIC PLACE (e.g., THEATER, MEETING)	_____
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	_____
LYING DOWN TO REST IN THE AFTERNOON IF CIRCUMSTANCES PERMITTED	_____
SITTING QUIETLY AFTER A LUNCH WITHOUT ALCOHOL	_____
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	_____
SITTING AND TALKING TO SOMEONE	_____

PULMONARY ASSOCIATES OF STAMFORD, P.C.

PATIENT INFORMATION SHEET

Patient_____ Home Phone_____

Cell Phone_____

Email Address_____

Responsible Party (if minor) _____

Street
Address_____

City_____State_____Zip_____

Sex M F Age _____ Birthdate_____SS#_____

Referring Physician_____

Immediate Problem_____

Employer_____Work Phone_____

Name of Primary Insurance_____

Name of Secondary Insurance_____

In Case of Emergency, who should be notified?_____

Phone_____Relation to patient_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign directly to Pulmonary Associates of Stamford, P.C., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Patient_____ Date_____

PULMONARY ASSOCIATES POLICY ON MEDICARE

Pulmonary Associates are participating Medicare Physicians. This means we agree to accept the Medicare approved charges as the full charge for our services. We will bill Medicare for 80% of these charges. Medicare law requires that you pay 20% coinsurance, any deductible or non-covered services. If you have additional insurance, it may pay these charges. I understand that I am responsible for the deductible, coinsurance and non-covered services as well as any legal expenses incurred, if needed, to ensure payment of my bill.

Signature of Patient_____ Date_____