SLEEP DIAGNOSTICS, INC.

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You have an appointment at Sleep Diagnostics Inc. For an in home "sleep study" X 2 CONSECUTIVE NIGHTS

Helena Directions: *We are in the Upper Level of the Professional Plaza on the corner of Missoula Ave. and Montana Ave. One block south of Helena High School and the building NORTH of Sage Medical Clinic. Park in the upper level parking lot.*
Missoula Directions: *We are in the Upper Level of the Montgomery Building on the west corner of Reserve St. and Spurgin Rd.*

KEEP this first page

Please fill out all paperwork. Return with unit

YOU WILL DO TWO CONSECUTIVE SLEEP STUDIES
ON EACH 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. Take your usual medications as instructed by your physician.
3. **Do not** take any naps.
4. Do not put any oils or lotions on your face, hands or arms so that the tape will stick
5. If you have nail polish on you MUST remove this or the oximeter probe will not read properly.

WHAT TO SLEEP IN:

1. Wear a cotton t-shirt under the recorder
2. **Do not** wear the recorder on bare skin
3. **Do not** wear silky or satiny night clothes as the effort band will slip and slide too much

What is a home sleep study?

A home 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: heart rate, breathing effort, airflow, oxygen saturations and body position. These signals are obtained from the correct placement of the sensors attached to the Stardust. 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 home sleep study?

The home sleep unit is mailed to you with written instructions. You will follow the instructions and sleep with the device then you will return the device according to the instructions with the return label provided.

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 studies A board certified sleep specialist will bill the professional component of the sleep studies for his/her interpretation report. (Just like when you have an x-ray. You get a separate bill from the radiologist)**

Please fill out all paperwork. Return with unit or email/fax it back prior to testing.

Patient Name: _____

NOCTURNAL DIARY (please answer all questions)

DATE OF STUDY: DAY 1 – **NEW BATTERIES** _____

WHAT TIME DID YOU GO TO BED? _____
HOW LONG DID IT TAKE YOU TO FALL ASLEEP(approximately)? _____
WHAT TIME DID YOU WAKE UP? _____
WHAT TIMES WERE YOU AWAKE AND FOR HOW LONG? _____

WERE YOU WEARING OXYGEN? _____
DID YOU TAKE A SLEEP AID? _____
IF YES, LIST MEDICATION, AMOUNT & TIME YOU TOOK IT?

DATE OF STUDY: DAY 2 - **REPLACE NEW BATTERIES** _____

WHAT TIME DID YOU GO TO BED? _____
HOW LONG DID IT TAKE YOU TO FALL ASLEEP(approximately)? _____
WHAT TIME DID YOU WAKE UP? _____
WHAT TIMES WERE YOU AWAKE AND FOR HOW LONG? _____

WERE YOU WEARING OXYGEN? _____
DID YOU TAKE A SLEEP AID? _____
IF YES, LIST MEDICATION, AMOUNT & TIME YOU TOOK IT? _____

Please thoroughly complete the attached sleep screening questionnaire (page 1-7) and return with the unit.

Feel free to add additional information that you feel may be pertinent to your sleep problem and was not addressed in the sleep screening questionnaire in this box below.

**Please complete paperwork and RETURN WITH DEVICE

** You can also email it back to char@sdinc1.net or mail it back to: 900 N. Montana Ave. Suite A9 Helena MT. 59601 Thank you.

Sleep Screening Questionnaire

www.sleepwellmt.com

PLEASE PRINT YOUR NAME *EXACTLY* AS IT APPEARS ON YOUR INSURANCE CARD.
WE WILL NEED A COPY OF YOUR INSURANCE CARD. THANK YOU.

Last Name _____ First Name: _____ MI _____ Ms., Mrs. or Mr. _____

Address: _____ City: _____ State _____ Zip _____

D.O.B. _____ Telephone: _____ Cell: _____ Work: _____

SS #: mandatory _____ Sex: _____ Ht in inches _____ Wt in lbs _____

#1 Insurance Name: _____ ID # _____ Grp # _____

Policy Holder Name and DOB: _____

#2 Insurance Name: _____ ID # _____ Grp # _____

Policy Holder Name and DOB: _____

Email Address:

Employer and Employer Phone # _____

List ALL MEDICATIONS and SLEEP AIDS: ******BE SURE TO LIST OXYGEN IF YOU USE IT

Medication	Dosage *Example:: 200mg twice a day*	Times of day that you take it *Example: 8am, 8pm*

( ) I have had a recent weight gain in past 6 months. ? lbs. [ ] ( ) I have had a recent weigh loss in past 6 months. ? lbs [ ]

Use the following space to 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:

Special Needs Section: Please put an X in front of all that apply and answer any additional questions.

- [ ] I walk independently without assistance
- [ ] I use a cane to walk
- [ ] I use a walker to assist me with walking
- [ ] I use a wheelchair
- [ ] I need assistance getting in and out of bed
- [ ] I sleep with more than one pillow

How many, where at and why? _____

- [ ] I sleep in a recliner
- [ ] I have a hearing problem
- [ ] I wear a hearing aid
- [ ] I wear dentures
- [ ] I wear dentures at night.

Bedtime Habits: Please fill in your answers to the right.

My normal bedtime is at: _____

I usually get up for the day at: _____

My bedtime varies on weekends between? _____

It usually takes me _____ minutes to fall asleep

I usually get up to use the bathroom _____ times in the night

I am awake _____ times in the night

I am usually awake at the following times in the night: _____

The total time I am awake in the night is _____ minutes

Please put an X in front of all that apply and remark on the days per week on average that you do this

_____	I drink caffeinated beverages within 2 hrs of bed	Days per week on average that you do this _____
_____	I drink alcohol within 2 hours of bed	Days per week on average that you do this _____
_____	I use tobacco (smoke/chew) within 2 hrs of bed	Days per week on average that you do this _____
_____	I exercise within 2 hours of bed	Days per week on average that you do this _____
_____	I take medications to aid sleep	Days per week on average that you do this _____

If yes which medication _____

Caffeine, Alcohol and Tobacco section: Please indicate how many of each of the following do you consume PER DAY?

Coffee w/ caffeine- 6 oz cups	_____	Per day	Wine – 6 oz glasses	_____	Per day
Soda w/ caffeine -12 oz cans	_____	Per day	Hard Liquor in ounces	_____	Per day
Tea w/ caffeine 12 oz glasses	_____	Per day	Beer – 12 oz can	_____	Per day
Energy drinks(Monster-Red Bull)	_____	Per day	Cigarettes – packs	_____	Per day
Water 8 oz glasses	_____	Per day	Chewing Tobacco – cans	_____	Per day
Chocolate in ounces	_____	Per day	Cigars - number	_____	Per day

Smoking History : Please answer all questions accurately

Years you have smoked _____

Average packs per day over that whole time period _____

Have you quit for good? _____

What year did you quit? _____

Please put an X in front of all that apply

	I am a light sleeper		I have had a tonsillectomy
	I am a deep sleeper		I have been told I have a deviated septum
	I am most energetic in the morning		I have had a deviated septal repair
	I am most energetic in the evening		I have had sinus surgery

History section: Please put an X in front of all that apply AND Describe how long you have had the problem.

	Insomnia (difficulty falling or staying asleep)	
	Restless Sleep	
	Non Restorative Sleep (waking unrefreshed)	
	Frequent nighttime awakenings	
	Sleepiness during the day	
	Snoring	
	Sleep Apnea (pauses in breathing during sleep)	
	Nightmares	
	Sleepwalking	
	Acting out dreams (punching, kicking, grabbing?)	

Symptoms section: Please put an X in front of all that apply and mark the frequency

	I have allergy problems		Rarely		Occasionally		Frequently
	I have sinus problems		Rarely		Occasionally		Frequently
	I wake with a dry mouth.		Rarely		Occasionally		Frequently
	I have trouble breathing through my nose		Rarely		Occasionally		Frequently
	I take medications to help me sleep		Rarely		Occasionally		Frequently
	As an adult I wet the bed		Rarely		Occasionally		Frequently
	I wake with heartburn		Rarely		Occasionally		Frequently
	I wake with night sweats		Rarely		Occasionally		Frequently
	I wake short of breath		Rarely		Occasionally		Frequently
	I wake gasping		Rarely		Occasionally		Frequently
	I wake with headaches		Rarely		Occasionally		Frequently
	I wake with pain		Rarely		Occasionally		Frequently
	If yes what kind of pain?						

Sleep Habit section: Please put an X in front of all that apply and mark the frequency

	I have an irregular sleep schedule		Rarely		Occasionally		Frequently
	I am a shift worker		Evenings		Nights		Rotating
	Pets in my home disturb my sleep		Rarely		Occasionally		Frequently
	My pets sleep in my bedroom		Rarely		Occasionally		Frequently
	My sleep is disturbed by caring for others		Rarely		Occasionally		Frequently
	My productivity is down because of my sleep		Rarely		Occasionally		Frequently
	I use tobacco when awake at night		Rarely		Occasionally		Frequently
	I eat when awake at night		Rarely		Occasionally		Frequently
	I drink when awake at night		Rarely		Occasionally		Frequently
	I grind my teeth at night		Rarely		Occasionally		Frequently

Motor Vehicle section: Please put an X in front of all that apply, mark the frequency and explain further if required

☐ I fall asleep while driving ☐ Rarely ☐ Occasionally ☐ Frequently

Please explain _____

☐ I pull over to nap to avoid sleeping while driving ☐ Rarely ☐ Occasionally ☐ Frequently

☐ I have had a motor vehicle accident because I fell asleep at the wheel

Please Explain _____

Put an X in front of the severity of your sleep problem (how you perceive it to be)

☐ Mildly Upsetting
☐ Moderately Upsetting
☐ Very Severe
☐ Extremely Severe
☐ Totally Incapacitating
☐ I don't think I have a sleep problem

Oxygen, CPAP, and HTN section: Please put an X in front of all that apply and answer all other questions or explain further.

☐ I want help with my sleep problem _____
☐ I am willing to wear CPAP if necessary _____
☐ I am **NOT** willing to wear CPAP (WHY NOT?) _____
☐ I am claustrophobic _____
☐ Other blood relatives have sleep problems (WHO and WHAT?) _____
☐ I wear oxygen (WHAT setting, WHEN and WHO is your company) _____
☐ I wear CPAP (WHAT is you settings and WHO is your company) _____
☐ I have high blood pressure _____
☐ I take medication to help control high blood pressure _____

Insomnia and Mood section: Please put an X in front of all that apply and mark the frequency

☐	I have insomnia	☐	Rarely	☐	Occasionally	☐	Frequently
☐	My insomnia is related to stress						
☐	My insomnia is related to pain						
☐	I feel depressed	☐	Rarely	☐	Occasionally	☐	Frequently
☐	I feel anxious	☐	Rarely	☐	Occasionally	☐	Frequently
☐	I feel muscle tension at night	☐	Rarely	☐	Occasionally	☐	Frequently
☐	My mind races when I'm trying to fall asleep	☐	Rarely	☐	Occasionally	☐	Frequently
☐	I sleep better in an unfamiliar place						
☐	I sleep worse in an unfamiliar place						
☐	I read, work or watch TV in bed	☐	Rarely	☐	Occasionally	☐	Frequently
☐	My sleep is disturbed by heat	☐	Rarely	☐	Occasionally	☐	Frequently
☐	My sleep is disturbed by cold	☐	Rarely	☐	Occasionally	☐	Frequently

Eye Questions: Please put an X in front of ALL that apply and MARK the frequency

☐	My eyes are dry	☐	Rarely	☐	Occasionally	☐	Frequently
☐	My eyes are red	☐	Rarely	☐	Occasionally	☐	Frequently
☐	My eyes are irritated	☐	Rarely	☐	Occasionally	☐	Frequently
☐	I have been told I have glaucoma	☐	YES	☐	NO	☐	
☐	I have an Ophthalmologist	☐	YES	☐	NO		
The last time I saw my Ophthalmologist was:							

Movement / Position section: Please put an X in front of all that apply and remark on the frequency if applicable

	Weird sensations in my legs keep me from falling asleep.		Rarely		Occasionally		Frequently
	My legs feel like they have to move, but do not keep me awake		Rarely		Occasionally		Frequently
	I have nighttime leg cramps		Rarely		Occasionally		Frequently
	I toss and turn in sleep		Rarely		Occasionally		Frequently
	I prefer to sleep on		Back		Sides		Belly
	I sleep on my back		Rarely		Occasionally		Frequently

Nap and Narcolepsy section: Please put an X in front of all that apply and mark the frequency and explain if required

	I take intentional naps		Rarely		Occasionally		Frequently
	How many naps per week on average?		Per week				
	How many naps per day on average?		Per day				
	How long do you nap for?		Minutes				
	After I nap I feel refreshed		Rarely		Occasionally		Frequently
	I dream when I nap		Rarely		Occasionally		Frequently
	I have hallucinations as I'm falling asleep		Rarely		Occasionally		Frequently
	I have hallucinations as I'm waking up		Rarely		Occasionally		Frequently
	I can't move sometimes even though I know I am awake		Rarely		Occasionally		Frequently
	I have episodes of muscle weakness at times of emotional intensity (laughing or crying really hard)		Rarely		Occasionally		Frequently
IMPORTANT If yes please use this space to describe these episodes **IN DETAIL**							

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:

Please list any previous sleep testing that you have had. Where you had the testing, when and what the results were

Date of Testing	Where testing was performed	What type of Testing	Results of Sleep Testing

Patient Name _____ Date _____

EPWORTH SLEEPINESS SCALE – (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?
Even if you haven't done some of the se activities recently, think about how they would have affected you.
> 8 may indicate excessive daytime sleepiness.

Use this scale to choose the most appropriate number for each situation:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing
It is really important that you report a number of 0-3 on each of the questions.

SITUATION	Chance of Dozing 0-3
Sitting and reading	
Watching television	
Sitting inactive in a public place such as 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 would permit that	
Sitting and talking to someone	
Sitting quietly after lunch (where you have had no alcohol)	
In a car, while stopped for a few minutes in traffic	
Total Score	

FATIGUE SEVERITY SCALE - (FSS)

This scale reflects the fatigue you felt in the PAST WEEK and how it impacted you.
The lower the numbers indicate less fatigue, while the higher numbers indicate more fatigue.
It is important that you report a number of (1-7) for every question.
> 36 may indicate excessive fatigue.

DURING THE PAST WEEK:		Your Score ▼
I felt fatigued and had less motivation	1 2 3 4 5 6 7	
I felt fatigued and did not desire to exercise	1 2 3 4 5 6 7	
I felt fatigued often	1 2 3 4 5 6 7	
I felt fatigue that interfered with my physical functioning	1 2 3 4 5 6 7	
I felt fatigued which caused me frequent problems	1 2 3 4 5 6 7	
I felt fatigued which prevented sustained physical functioning	1 2 3 4 5 6 7	
I felt fatigued and couldn't carry out certain duties and responsibilities	1 2 3 4 5 6 7	
Fatigue was among the 3 most disabling symptoms	1 2 3 4 5 6 7	
Fatigue interfered with my work, family or social life	1 2 3 4 5 6 7	
	Total Score	

SLEEP DIAGNOSTICS, INC
BED PARTNER SURVEY

Please have a spouse, family member, or someone who has observed you sleeping, complete this page

Name of Patient: _____

Name of Observer: _____

Briefly describe the individual's sleep problems. How long have you noticed these sleep problems?
How often do they occur? Why do you think they need a sleep study? How is their sleep problem negatively affecting your life?

Bed Partner section: Please put an X by all that apply and remark on the frequency if applicable

	He/ She snores		Rarely		Occasionally		Frequently
	If yes state the level of		Quiet		Medium		Loud
	He/She kicks when sleeping		Rarely		Occasionally		Frequently
	He/ She falls asleep involuntarily during the day		Rarely		Occasionally		Frequently
	He/She is hard to wake in the morning		Rarely		Occasionally		Frequently
	He/She wakes up in the night		Rarely		Occasionally		Frequently
	He/She wakes with a snort or gasp		Rarely		Occasionally		Frequently
	He/She stops breathing in sleep		Rarely		Occasionally		Frequently
	If yes what body position is it related to		Back		Side		Doesn't matter

Date at Beginning of week _____

	Day 1	Day 2	Day 3	Day 5	Day 5	Day 6	Day 7
f							
e day:							
ay: epy							

	Day 1	Day 2	Day 3	Day 5	Day 5	Day 6	Day 7
asleep							
ings							

tes: