SLEEP DIAGNOSTICS, INC

www.sleepwellmt.com

900 N. Montana Ave. Suite A9, Helena, MT 59601 Phone: 406-449-8999 Fax 406-449-8989

You have an appointment at Sleep Diagnostics Inc. For an all-night "sleep study"

PATIENT NAME	TIME	DAY OF WEEK	MONTH	DAY OF MONTH

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.*

Keep this first page---please complete all paperwork and mail it back in envelope provided.

(24 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 *****

ON THE DAY OF YOUR SLEEP STUDY: Do not take any naps if possible.

1. Eat meals as usual, but don't drink caffeinated drinks (such as coffee, cola or tea) after 1:00 pm.
2. Please make certain that your hair is clean and **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 (if you take them right before bed then bring them with you to take at that time)
5. 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.
6. For women: You will need to **REMOVE YOUR NAIL POLISH**! (don't get your nails done prior to the study or we will have to mess it up ☹)
7. If you have long hair, it would help to loosely braid your hair. There is **NO SHOWER** available in the morning.

WHAT TO BRING: DO NOT BRING A GUEST UNLESS THEY ARE A DIRECT CAREGIVER AND APPROVED BY OUR STAFF

1. Bring nightwear to sleep in, (should be 2-piece, cotton is best) (**t-shirt and shorts are ideal)**
2. Bring medications that you take before bed, including any sleep aids. We do not provide sleep medication. If you have a sleep aid that you take regularly, bring it with you. If you don't take a sleep aid regularly, we would prefer to see a normal night of sleep. If you feel strongly that you may not be able to sleep, then talk to your doctor about a sleep aid. You will need to have a family member or friend give you a ride home the next day. Remember to bring glucose testing if you have it in the event you need to test your glucose levels.
3. Bring your insurance cards, reading material (if you read before bed), snack (if you snack before bed – refrigerator/ microwave is available)

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 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 technician about 40 minutes to attach small sensors to your head, chest stomach and legs and you will be asked to fill out short pre-sleep questionnaire. After set up you can unwind as usual (read, or watch TV). The tech will monitor you from another room. If you need anything just ask aloud in a normal speaking voice and the tech will come into the room to aid you. You can use the restroom at any time in the night, it is an easy process (urinal is available upon request). If a breathing problem is observed during your study the tech may awaken you to ask you to try a device that treats breathing problems during sleep. Generally the tech will discuss this with you prior to bed. The device is PAP (Positive Airway Pressure) and it includes a small mask that fits over your nose or silicone plugs in your nostrils.

What is the procedure after a sleep study?

It will take approximately 10-14 working days for the study results to get back to your primary care physician. He/She will contact you concerning the results. A copy of the interpretation and a sleep center survey will be mailed to you.

*****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)**

NOTE: FIREARMS ARE NOT PERMITTED IN THE SLEEP CENTER

TYPES OF CARE/SERVICE AVAILABLE

Sleep Diagnostics' offers the following services

- Diagnostic in-facility testing
- Split Night in-facility sleep testing
- Titration in-facility sleep testing
- CPAP titration in-facility testing
- Multiple Sleep Latency Testing
- CPAP and supplies for non-Medicare/Medicaid patients
- Nocturnal pulse oximetry testing

CARE and SERVICE LIMITATIONS

Sleep Diagnostics' has the following limitations to care and services

- Weight limit for in-facility testing is 425lbs with exception from medical director
- Age criteria is 5yr-90yr (Special considerations if ≥ 3yr or ≤ 95yr must be approved by Medical Director)
- Patient must be able to transfer into and out of bed independently or caregiver must be present
- Patient must be able to perform activities of daily living independently
- Medications are never dispensed by our staff. Patients must come with any medications that they need to take.

HOURS OF OPERATION

Sleep Diagnostics' office hours are Days Mon-Fri 8:00 AM to 5:00 PM Sleep studies are by appointment only Mon-Sun 7:00 PM to 7:00 AM.

CONTACT INFORMATION

Sleep Diagnostics' contact information is as follows:
Phone Number: 406-449-8999 extension 1 Toll Free 1-855-449-8999
Fax Number: 406-449-8989
Website: www.sleepwellmt.com

CHARGES FOR SERVICES

Sleep Diagnostic will provide a copy of the charges for services time of service.

Clients can call the contact information listed above prior to service and request verbal confirmation of the charges for any services scheduled.

** You can mail it back to: 900 N. Montana Ave. Suite A9 Helena MT. 59601 or bring it with you to your appt.

Sleep Screening Questionnaire

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

DATE _____

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 _____

Primary Insurance Name _____ ID # _____ Grp # _____

Policy Holder Name and DOB: _____

Second. Insurance Name _____ ID # _____ Grp # _____

Policy Holder Name and DOB: _____

Email Address: _____

Employer and Employer Phone # _____

Emergency Contact Name _____ Phone Number _____

List ALL prescribed and OTC MEDS. Be sure to list OXYGEN and amt. if used. If you use **MARIJUANA** please report on amount and frequency.	**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:

History section: Please put an X in front ONLY THOSE 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	
	Excessive sleepiness during the day	
	Snoring	
	Witnessed Sleep Apnea (pauses in breathing during sleep)	
	Nightmares	
	Sleepwalking	
	Acting out dreams (punching, kicking, grabbing?)	
	Moderate Memory Issues	

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

My normal bedtime is at: _____

I usually get up for the day at: _____

It usually takes me _____ minutes to fall asleep

I am awake _____ times in the night

I wake up for this/these reasons: _____

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

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

Symptoms section: Please MARK THE FREQUENCY

I have difficulty breathing through my		Never		Rarely		Occasionally		Frequently
I wake with a dry mouth.		Never		Rarely		Occasionally		Frequently
I am incontinent (wet the bed)		Never		Rarely		Occasionally		Frequently
I wake with heartburn		Never		Rarely		Occasionally		Frequently
I wake with night sweats		Never		Rarely		Occasionally		Frequently
I wake short of breath		Never		Rarely		Occasionally		Frequently
I wake gasping		Never		Rarely		Occasionally		Frequently
I wake with headaches		Never		Rarely		Occasionally		Frequently
I wake with pain		Never		Rarely		Occasionally		Frequently
If yes what kind of pain?								

Please put an X in front of ONLY THOSE 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 nicotine (smoke/chew/vape) within 2 hrs 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 _____

Smoking / Vaping History: DO YOU OR DID YOU SMOKE or VAPE or BOTH? CIRCLE ONE PLEASE

Number of Years you have SMOKED if never, write NEVER _____ (SMOKING) Avg. packs per day over that whole time? _____

Have you quit smoking for good? _____ If you have quit FOR GOOD, what year did you quit? _____

If you still smoke how many packs per day do you smoke? _____

Number of Years you have VAPED if never, write NEVER _____ (VAPING) Avg. # of puffs per day over that whole time? _____

Have you quit vaping for good? _____ If you have quit FOR GOOD, what year did you quit? _____

Do you vape **nicotine** OR **marijuana** OR **BOTH**? _____

If you still vape, how many puffs of vaped material do you vape per day? _____

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

Special Needs: Please put an X in front of all that apply

Surgical History Please check all that apply		OTHER MEDICAL HISTORY Please check all that apply			
	Cardiac bypass (CABG)		Coronary Artery Disease		Seizures
	Cardiac stents		Heart Attack		COPD
	I have a pacemaker		High blood pressure even if treated		Asthma
	Lung resection		Atrial Fibrillation		Pulmonary Hypertension
	Cardioversion for atrial fibrillation		Other cardiac arrhythmia		Restrictive lung disease
	Pneumothorax with chest tube	Which arrhythmia?			Tuberculosis
	Tonsillectomy		Blood clots in lung		Hepatitis
	Adenoidectomy		Deep Vein Thrombosis		Kidney Disease
	Gastric Bypass		High Cholesterol		GERD (gastric reflux)
	Septoplasty (deviated nasal septum repair)		Congestive Heart Failure		Liver Disease
	Sinus surgery		Stroke		Diabetes Type 1
	Jaw advancement surgery		Chronic Fatigue		Diabetes Type 2
	Other facial surgery _____		Depression		Anemia
	I have a Vaso-vagal nerve stimulator in place		Anxiety		HIV
	I have an Inspire Device implanted		Diagnosed Dementia		Hypothyroidism
			Bipolar Disorder		Restless Leg Syndrome
	Other _____		PTSD		Kyphosis
	Other_____	Other: _____			Scoliosis

	I have a hearing aid or hearing loss		I need assistance getting in and out of bed
	I wear dentures		I use a cane or walker to walk
	I wear my dentures at night		I sleep with more than 1 pillow under my head
	I wear incontinence pads to bed		I use a wheelchair
	I have incontinence issues at night		I need to sleep in a recliner

Sleep Habit section: Please MARK THE FREQUENCY

I have an irregular sleep schedule		Never		Rarely		Occasionally		Frequently
Pets in my home disturb my sleep		Never		Rarely		Occasionally		Frequently
My pets sleep in my bedroom		Never		Rarely		Occasionally		Frequently
My sleep is disturbed by caring for others		Never		Rarely		Occasionally		Frequently
My productivity is down because of my sleep		Never		Rarely		Occasionally		Frequently
I use tobacco when awake at night		Never		Rarely		Occasionally		Frequently
I grind my teeth at night		Never		Rarely		Occasionally		Frequently
	I am a shift worker		Evenings		Nights		Rotating	

Motor Vehicle section: Please mark the frequency and explain further if required

I fall asleep while driving		Never		Rarely		Occasionally		Frequently

Please explain

I pull over to nap to avoid sleeping while driving		Never		Rarely		Occasionally		Frequently
I have had a motor vehicle accident because I fell asleep		Never		Rarely		Occasionally		Frequently

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: Put an X in front of ONLY THOSE THAT APPLY & answer all 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 and what MASK do you wear? FULL FACE OR NASAL?	
	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 ONLY THOSE 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
	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, TV in bed		Rarely		Occasionally		Frequently
	My sleep is disturbed by being too hot		Rarely		Occasionally		Frequently
	My sleep is disturbed by being too cold		Rarely		Occasionally		Frequently

Eye Questions: Please put an X in front of ONLY THOSE 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 had my eyes checked was:						

Movement / Position section: Please put an X in front of ONLY THOSE THAT APPLY and remark on the frequency if applicable

	Unpleasant sensations in my legs keep me from falling asleep.		Rarely		Occasionally		Frequently
	Does the above symptom begin or worsen when you try to rest?		YES		NO		
	Does the above symptom worsen in the evening or closer to bedtime?		YES		NO		
	Is the above symptom partially or fully relieved after you move your legs, even if just for a moment?		YES		NO		
	How many nights per week do your leg issues cause insomnia?		Nights per week				
	I have nighttime leg cramps		Rarely		Occasionally		Frequently
	I prefer to sleep on		Back		Sides		Belly
	I sleep on my back		Never		Rarely		Occasionally		Frequently

Nap and Other section: Please mark the frequency and explain if required

I take intentional naps		Never		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 each time on avg?		Minutes						
After I nap I feel refreshed		Never		Rarely		Occasionally		Frequently
I dream when I nap		Never		Rarely		Occasionally		Frequently
I have hallucinations as I'm falling asleep		Never		Rarely		Occasionally		Frequently
I have hallucinations as I'm waking up		Never		Rarely		Occasionally		Frequently
I can't move sometimes even though I know I am awake		Never		Rarely		Occasionally		Frequently
I have episodes of muscle weakness at times of emotional intensity (laughing or crying really hard)		Never		Rarely		Occasionally		Frequently
IMPORTANT If yes to episodes of muscle weakness, Please use this space to describe these episodes **IN DETAIL**								

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 these activities recently, think about how they would have affected you. > 8 may indicate excessive daytime sleepiness. A score of 8 or more is considered excessively sleepy

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	

STOP BANG QUESTIONNAIRE

	YES	NO
Do you **S**nore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?		
Do you often feel **T**ired, fatigued, or sleepy during the day (such as falling asleep during driving or talking to someone)?		
Has anyone **O**bserved you stop breathing or choking /gasping during your sleep?		
Do you have or are you being treated for high blood **P**ressure?		
Is your **B**ody mass index more than 35 kg/m2?		
Are you **A**ged – older than 50?		
Is your **N**eck size large: For male, is your shirt collar 17 inches or larger? For female, is your shirt collar 16 inches or larger? (Measured around the Adam's apple)		
Is your **G**ender male?		
TOTAL NUMBER OF YES ANSWERS		

Each **YES** question is worth 1 point and 4 or more points is positive for suspected sleep apnea.

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
	He/She acts out their dreams? IE: Punches, kicks, yells and can remember if you wake them what they were dreaming about and why their actions match what was happening in the dream?			How often?			

Patient Name _____ Date at Beginning of week _____

Complete at Bedtime	Day 1	Day 2	Day 3	Day 5	Day 5	Day 6	Day 7
Naps (Number, time, length of naps)							
Alcoholic Drinks (How many and what time)							
Overall Stress level during the day: High Moderate Low							
Rate how you felt Overall today: Very tired/sleepy Somewhat tired/sleepy Fairly Awake Wide Awake							
Irritability overall today: None Some Moderate Very High							

Complete in Morning	Day 1	Day 2	Day 3	Day 5	Day 5	Day 6	Day 7
Time you went to Bed							
Estimated time it took to fall asleep							
Estimated number of awakenings							
Estimated total time spent awake							
Time you work up for the day							
Estimated amt. of sleep in hours							

Please add any additional notes:	