NOCTURNAL OXIMETRY INTAKE FORM

Date: _____ Referring Provider _____ Fax # _____ Oximeter # _____

Last Name _____ First Name: _____ MI _____

Address: _____ City: _____ State _____ Zip _____

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

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

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

Policy Holder Name and DOB: _____

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

Policy Holder Name and DOB: _____

EPWORTH SLEEPINESS SCALE AND SCORE

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

SITUATION	SCORE
Sitting and Reading	
Watching TV	
Sitting inactive in a public place such as a theatre or a meeting	
As a passenger in a car for an hour without a break (and you trust the driver)	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car while stopped for a few minutes in traffic	
Total Score	

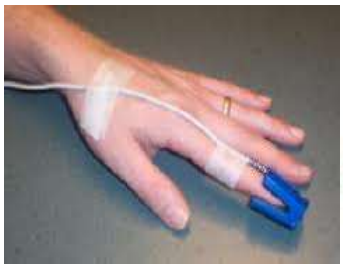
Daytime Symptoms and/or complaints: (please check appropriate symptoms)

☐	Excessive Daytime Sleepiness	☐	Snoring
☐	Wake with a dry mouth	☐	High Blood Pressure
☐	Tired no matter how much sleep I get	☐	Frequent nighttime awakenings
☐	I am a smoker	☐	I smoke within 2 hours of bedtime
☐	My legs feel like they have to move and sometimes PREVENT me from falling asleep at night.		

Do you wear oxygen?	☐	YES	If yes what liter flow?	☐	LPM	☐	NO
Do you wear CPAP?	☐	YES	If yes what pressure?	☐	cmH2O	☐	NO
What style of mask ?	☐	FULL FACE MASK		☐	NASAL MASK		

STEP 1:
REMOVE FINGERNAIL POLISH ON THE FINGER YOU WILL BE USING. MAKE SURE THE SENSOR IS PLUGGED INTO THE UNIT WITH 'NINON'FACING FORWARD.

STEP 2:
PUT SOFT PROBE ON FINGER (WIRE SHOUD BE ON TOP OF FINGER) AND TAPE IN PLACE TAPE (TIGHT TO THE WIRE LOOSE TO YOUR FINGER)
YOU WANT THE PROBE TO BE OVER THE FLESHY PAD OF YOUR FINGER



STEP 3:
PUSH ON/OFF BUTTON TO TURN UNIT ON. NUMBERS WILL DISPLAY IN OXYGEN LEVEL AND HEART RATE. INDICATOR LIGHT WILL FLASH GREE WITH YOUR PULSE RATE.
GO TO SLEEP AND WEAR ALL NIGHT.
IF YOU GET UP TO USE THE RESTROOM TAKE THE WHOLE UNIT WITH YOU BE CAREFUL IT IS A $1000.00 UNIT.

STEP 4:
WHEN YOU WAKE UP PRESS AND HOLD THE ON /OFF BUTTON DOWN UNTIL SCREEN GOES BLACK THEN RELEASE.

STEP 5:
RETURN UNIT AS DIRECTED BY YOUR SET UP TECHNICIAN. IF MAILED RETURN BY MAIL IN ENVELOPE PROVIDED **WITH ALL PAPERWORK!**

IF THE SENSOR FALLS OFF DURING THE NIGHT:
1. REPLACE THE SENSOR ON YOUR FINGER
2. CHECK THAT THE OXIMETER IS ON AND DISPLAYING NUMBERS
3. IF THE OXIMETER IS OFF, PRESS THE ON/OFF BUTTON AND TURN IT BACK ON.

IF THE INDICATOR LIGHT BLINKS YELLOW OR RED FOR SEVERAL MINUTES:
1. REPOSITION THE SENSOR ON FINGER
2. TRY A DIFFERENT FINGER
3. CONTINUE THE TEST

IF THE LOW BATTERY INDICATOR IS YELLOW:
1. DO NOT REPLACE BATTERIES
2. CONTINUE THE TEST
3. LET US KNOW WHEN YOU DROP OFF THE TEST

Helena Office	Missoula Office	Butte Office
900 N. Montana Ave. Ste A9 Helena, MT 59601	1211 S. Reserve, Ste 203 Missoula, MT 59804	400 W. Granite Butte MT. 59701
Phone (406) 449-8999 Fax (406) 449-8989	Phone (406) 542-4784 Fax (406) 543-1150	Phone (406)782-4595 Fax (406) 782-4355

Nocturnal Pulse Oximetry Diary

Date of Test:_____

Patient Name:_____

Did you wear oxygen? _____ NO _____ YES (If YES, what liter flow?) _____ lpm

Did you wear CPAP? _____ NO _____ YES (if YES, what CPAP setting?) _____cmH2O

Time to Bed: _____

About how long did it take you to fall asleep?_____

How many times did you get up in the night?_____, at what times?

Time and reason_____

Time and reason_____

Time and reason_____

Final wake up time: _____

Comments or problems or other significant medical history:

_____

_____

_____

_____

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