

## INSTRUCTIONS FOR SLEEP STUDY

Patient Name: \_\_\_\_\_

Your study will be done on: \_\_\_\_\_

Please arrive at the appointed time of: \_\_\_\_\_

- 1) Try to maintain your usual daytime schedule. Avoid unusual exercise and unusual meals.
- 2) **DO NOT TAKE NAPS ON THE DAY OF YOUR STUDY.**
- 3) Take only your regular medications on the day of your study unless directed by your doctor.
- 4) Please bring something comfortable to sleep in.
- 5) Please arrive with clean, dry hair. Do not use spray, oils, or gels.
- 6) Patients will need to shampoo their hair after each study (due to the use of paste with electrodes on scalp). For women who have hair pieces or hair extensions, or for women who have their hair done weekly, please arrange your appointment accordingly.
- 7) Women, please do not wear any make-up.
- 8) You may bring a favorite pillow or blanket to make you feel more comfortable.
- 9) Do not wear any lotions or oils on the body.
- 10) Please notify us as early as possible if you need to reschedule your appointment.
- 11) Please avoid caffeinated beverages after 6:00 p.m.
- 12) Please eat dinner before your appointment. Meals are not served at the lab.
- 13) Please bring your list of medications.
- 14) Please do not arrive before the appointed time of 8:30pm – our office is closed until 8pm.
- 15) Wake up time will be between 5:00am and 5:30am the next morning.
- 16) Please complete the patient information packet and return to the lab on the night of your study.

### DIRECTIONS TO CLINIC

We are located at 2020 W Pinhook Rd, suite 303 in Pinhook Office Court. Our driveway is between the Midsouth Bank building and Iberia Bank. (Go all the way to the back. We are in the brown brick buildings. Please feel free to call with any questions or concerns that you may have. 337-289-0241

#### **New Roads Lab**

230 Roberts Dr Suite 1  
New Roads, La  
225-634-4585

#### **Abbeville Lab**

108 S Louisiana  
Abbeville, La 70510  
337-893-7044

#### **Baton Rouge Lab**

7932 Picardy Ave Suite D  
Baton Rouge, La 70509  
225-761-7893  
(Off Essen Lane, next to Family Eye Center)

# *PATIENT INFORMATION SHEET*

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #s: (Home)-\_\_\_\_\_ (Work)-\_\_\_\_\_

Phone #: (Cell) - \_\_\_\_\_ Emergency Contact #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Other

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Work Status: \_\_\_\_\_ Employed \_\_\_\_\_ Student \_\_\_\_\_ Retired

Employer: \_\_\_\_\_

Referred By: \_\_\_\_\_

## *INSURED INFORMATION*

Policy Holder's Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Relation to Patient: (circle one) Self Child Husband Wife Other

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #s: (Home)-\_\_\_\_\_ (Work)-\_\_\_\_\_

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Have you met your in-network deductible for the calendar year? \_\_\_Y \_\_\_N

How much is your in-network deductible per calendar year? \_\_\_\_\_

How much has been satisfied towards that amount? \_\_\_\_\_

*SECONDARY INSURANCE*

Policy Holder's Name: \_\_\_\_\_ Sex: \_\_\_\_\_  
Relation to Patient: (circle one)    Self    Child    Husband    Wife    Other  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #s: (Home)- \_\_\_\_\_ (Work)- \_\_\_\_\_  
SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
Employer: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Claims Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

*GUARANTOR (IF OTHER THAN PATIENT)*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #s: (Home)- \_\_\_\_\_ (Work)- \_\_\_\_\_  
SS#: \_\_\_\_\_

For medical services rendered to myself or my dependent(s), I hereby authorize the following release of any information to obtain medical examination, treatment, and/or payment (assignment of benefits to be valid until revoked by me in writing). Photocopies of this form are to be as valid as the original.

I UNDERSTAND THAT HAVING INSURANCE COVERAGE DOES NOT RELEASE ME OF THIS LIABILITY.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

# *LOUISIANA SLEEP DIAGNOSTICS*

## *CONSENT FOR SLEEP STUDY*

I \_\_\_\_\_ have agreed to have a sleep study performed at LOUISIANA SLEEP DIAGNOSTICS. I understand that LOUISIANA SLEEP DIAGNOSTICS will accept my insurance carriers payment as payment in full for expenses incurred during the sleep study minus my deductible (Insurance Assignment). My only financial responsibility will be for any outstanding deductible not satisfied. Once billing has been received by my insurance carrier and an explanation of benefits has been generated I will be billed for the remaining balance of my deductible which is applied to the sleep study. I will be responsible for the entire balance of the bill if my insurance carrier refuses to pay for the study procedure due to my cancellation of the policy before the services are rendered, or if I refuse to provide information to my carrier that I alone must provide.

I also understand that I will be required to remain in bed for **approximately 6 hours** in order for this test to be complete. This testing is very complex and a trained technologist who specializes in this type of disorder is required to be present to administer the sleep study. In the event that the test is unable to be completed due to failure of the patient to fall asleep within a reasonable time or refusal of the study after the monitors and sensors have been applied, you will be billed for the technical time but not the professional portion of the fees.

I hereby authorize payment of medical benefits to LOUISIANA SLEEP DIAGNOSTICS or supplier for services.

*Patient's Signature/Guardian* \_\_\_\_\_ *Date* \_\_\_\_\_

*Witness* \_\_\_\_\_ *Date* \_\_\_\_\_

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO: \_\_\_\_\_ **Health Care Provider**

\_\_\_\_\_ **Street Address**

\_\_\_\_\_ **City/State/Zip**

I hereby authorize and request the above named health care provider to release the complete medical record in their possession concerning my illness and/or treatment during the period of \_\_\_\_\_ to:

Patient: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Signed: \_\_\_\_\_

Witnessed: \_\_\_\_\_

Date: \_\_\_\_\_

## *THE EPWORTH SLEEPINESS SCALE*

*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. Use the following scale to choose the most appropriate number for each situation:*

- 0 = **Never** doze
- 1 = **Slight chance** of dozing
- 2 = **Moderate chance** of dozing
- 3 = **High chance** of dozing

<i><b>Situation</b></i>	<i><b>Chance of Dozing</b></i>
Sitting and Reading	_____
Watching TV	_____
Sitting inactive, in a public place (a movie theater or a meeting)	_____
Passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and Talking with someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

*Patient Name* \_\_\_\_\_

1. Please **circle** the appropriate answer for the symptoms you experience either when sleeping or trying to fall asleep:

Yes	No	Heartburn	Yes	No	Fall out of bed	Bed Wetting	Yes	No
Yes	No	Night Sweats	Yes	No	Sour Belches	Sore Throat	Yes	No
Yes	No	Dry Throat	Yes	No	Leg Jerking	Leg Swelling	Yes	No
Yes	No	Irresistible urge to move legs						

- 2. What time do you normally go to bed? \_\_\_\_\_
- 3. How long does it normally take you to fall asleep? \_\_\_\_\_
- 4. How many times do you wake up at night? \_\_\_\_\_
- 5. What time do you usually **wake up** in the morning? \_\_\_\_\_
- 6. What time do you usually **get up** in the morning? \_\_\_\_\_
- 7. Do you normally sleep longer when you do not have to get up? Yes No  
How much longer? \_\_\_\_\_
- 8. Upon waking up in the morning, how do you feel? (circle one)  
completely rested    partially rested    not rested at all
- 9. Do you frequently have a headache when you wake up in the morning? Yes No

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ANSWER **YES** OR **NO**

- 1. As you fall asleep or wake up do you have vivid / lifelike dreams, or nightmares? Yes No
- 2. When you get angry / excited do you have sudden weakness or does any part of your body go limp? Yes No
- 3. As you are trying to fall asleep or wake up do you ever have an inability to move? Yes No
- 4. Have you ever driven / traveled somewhere and did not remember how you got there? Yes No

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- 1. What is your current weight? \_\_\_\_\_
  - 2. How long have you weighed this amount? \_\_\_\_\_
  - 3. What is the most that you have ever weighed? \_\_\_\_\_
  - 4. When did you weigh this amount? \_\_\_\_\_

List any surgeries you have had: \_\_\_\_\_

**Patient Name** \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient's Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Neck Size: \_\_\_\_\_

**SIGNS & SYMPTOMS** (please circle appropriately for each)

Yes	No	Snoring interrupted by silence and absence of breath			
Yes	No	Restless sleep	Yes	No	Heavy Snoring
Yes	No	Loss of energy	Yes	No	Forgetfulness
Yes	No	Irritability / Short Temper	Yes	No	Mood / Behavior Changes
Yes	No	Anxiety / Depression	Yes	No	Decreased interest in sex
Yes	No	Trouble concentrating	Yes	No	Daytime drowsiness

Do you have pain? Yes No

If so, please rate your pain from 1-5 (1 being very little pain, 5 being excruciating pain) \_\_\_\_\_



Quality of Pain: \_\_\_\_\_  
(Ex: sharp, location, duration, frequency)

1. Do you fall asleep easily under the following conditions?

- |                    |     |    |
|--------------------|-----|----|
| A. Sitting quietly | Yes | No |
| B. Driving         | Yes | No |
| C. Talking         | Yes | No |
| D. Eating          | Yes | No |
| E. Standing        | Yes | No |

List any medications you take regularly including over the counter medications, hormones, birth control, herbs, vitamins, etc. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any drugs in which you have an allergic reaction: \_\_\_\_\_  
\_\_\_\_\_

# ***IMPORTANT HEALTH INFORMATION***

Have you had any health problems in any of these areas?

***PLEASE CHECK ALL THAT APPLY:***

- Yes No Deviated Septum / Broken nose
- Yes No Sinuses
- Yes No Allergies
- Yes No Heart *Please Explain:* \_\_\_\_\_
- Yes No High blood pressure
- Yes No Asthma
- Yes No Other Respiratory Problems *Please explain:* \_\_\_\_\_
- Yes No Indigestion
- Yes No Kidney trouble *Please explain:* \_\_\_\_\_
- Yes No Sexual Function
- Yes No Cancer *Please explain:* \_\_\_\_\_
- Yes No Diabetes
- Yes No Hormone Imbalance
- Yes No Thyroid Disease
- Yes No Bullous Lung Disease
- Yes No Cerebral Spinal Fluid Leaks (CSF)
- Yes No Cribriform Plate Abnormalities
- Yes No History of head trauma *Please explain:* \_\_\_\_\_

Do you smoke? Yes No How long? \_\_\_\_\_

Did you previously smoke? Yes No How long? \_\_\_\_\_

Do you drink alcohol? Yes No How frequently? \_\_\_\_\_

Do you have any family members who have a sleep disorder? Yes No

Please explain: \_\_\_\_\_

List any other problems or symptoms that you may have that are not listed above:

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***Patient Name*** \_\_\_\_\_

