Wyoming
SLEEP DISORDERS CENTER

WWW.WSDCSLEEP.COM

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Cheyenne WY, 82009

Tel 307-638-4733 Fax 307-637-9108

Enclosed are some new patient forms we need you to fill out and bring with you to your scheduled appointment. If you have any questions prior to your appointment or while you are filling out this paperwork please don't hesitate to call our office.

In order to keep wait time to a minimum, we ask that you arrive fifteen minutes early for your appointment and bring a photo ID, your insurance card(s), any co-pay required by your insurance company, and the paperwork included in this packet. Due to the high volume of patients being seen in the Center, if you do not present your finished paperwork upon checking in for your scheduled appointment, you will be asked to reschedule.

Should you need to reschedule an appointment we would appreciate at least 24 hours notice to help us accommodate other patients, we thank you for courtesy in this.

As an office policy, if you are ten or more minutes late for an appointment, you will be asked to reschedule. Please be aware that there is a $75.00 fee for all no show appointments.

If you no show a sleep study appointment you will need to go back to your referring provider prior to out considering you again for the test. **We also reserve the rights to permanently decline your referral if you previously no showed, as no shows drives up the cost of care for everybody.**

Again, thank you for choosing the Wyoming Sleep Disorders center. We look forward to serving you.

Patients Personal Information

Last Name First Name Middle Initial

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

E-mail _____ Sex [ ] Male [ ] Female

Cell Phone _____ Work Phone_____

Home Address

_____ City_____ State_____Zip_____

Employer Name & Address

_____ City_____ State_____Zip_____

Responsible Party Information: Self [ ] Spouse [ ] Child [ ] Other_____

Last Name First Name Middle Initial

Date of Birth ___/____/_____ Social Security Number _____-_____-_____

E-mail _____

Cell Phone _____ Work Phone_____

Home Address

_____ City_____ State_____Zip_____

Primary Insurance

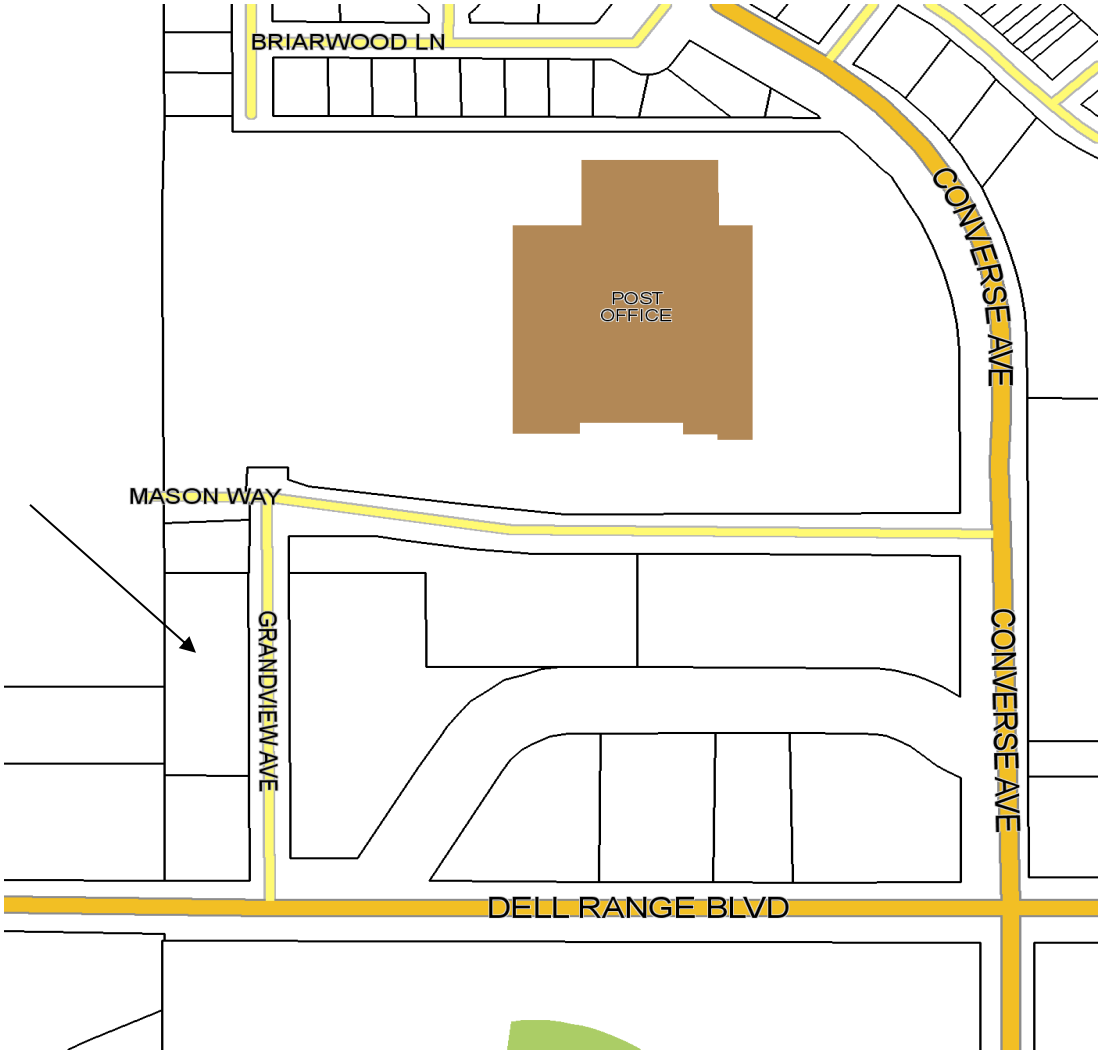
Name _____

Address_____ City_____ State_____Zip_____

Name of Insured_____ Date of Birth _____/_____/_____

Policy #_____ Group # _____

Location Map



Epworth Sleepiness Scale

Name_____ Date_____

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 the 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 follow scale to choose the most appropriate answer for each situation:

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total

Name_____ DOB_____

Usual work hours ( ) Day: _____ ( ) Evenings: _____

Provider that sent you _____

Please complete the following questionnaire by filling in the blanks and placing a check in the appropriate areas.

My Main Sleep Complaint is _____

( ) Trouble sleeping at night For how many months/ years _____

( ) Being sleepy during the day For how many months/ years _____

( ) Snoring For how many months/ years _____

( ) Unwanted behavior during sleep : Explain _____

Sleep Pattern	Work Days (Week Days)	Off Days (Weekends)
Typical bedtime	_____	_____
Typical amount of time to fall asleep	_____	_____
Typical amount of time to fall back asleep	_____	_____
Typical wake time	_____	_____
Desired wake time	_____	_____
What wakes you	_____	_____
Time you get out of bed	_____	_____
Total amount of sleep per night	_____	_____
number of naps per day	_____	_____

Past sleep Evaluation and Treatment

( ) I have had a previous sleep disorder evaluation What year? _____ Where? _____

( ) I have had previous overnight sleep studies What year? _____ Where? _____

Past Medical History

( ) Hypertension (High blood pressure)
( ) heart disease
( ) Diabetes
( ) Stomach or colon problems
( ) Lung problems/COPD/Asthma
( ) Reflux
( ) Fibromyalgia
( ) Stroke
( ) TIA "Light Stroke"
( ) Blackouts
( ) Seizures
( ) Back or joint problems
( ) Cancer
( ) Thyroid problems
( ) Hepatitis/Jaundice
( ) Hearing impairment
( ) Depression or severe anxiety
( ) Alcoholism
( ) Chemical dependency/abuse
( ) Surgeries ( ) Neck ( ) Throat ( ) Nasal

Female
( ) Premenstrual Syndrome
( ) Menopause

Male
( ) Prostate problems
( ) Erectile dysfunction/impotence

List other past surgeries/past hospitalization/injuries, dates& medications:

Please use an additional sheet if required.

Family History

Father: _____ Mother: _____ Siblings: _____

Other: _____ _____ _____

Social History

Marital Status: Single Married Separated Divorced Widowed

Alcohol Use: Never Type and Frequency _____

Drug Use: Never Type and Frequency _____

Occupation: _____

Habits:

Do you smoke? ( ) Yes ( ) No	If yes, What?	Amount per day	# of years
	( ) Cigarettes	_____ packs	_____Years
	( ) Cigars	_____ cigars	_____Years
	( ) Tobacco	_____ pipes	_____Years

Do you drink alcohol? ( ) Yes ( ) No	If yes, what?	Frequency	Amount per week
	( ) Beer	Daily/Weekends/Rarely	_____ # of cans
	( ) Wine	Daily/Weekends/Rarely	_____# of glasses
	( ) Liquor	Daily/Weekends/Rarely	_____ # of shots

Please check all of the following statements that are true about your sleep:

Sleep habits

( ) I usually watch TV or read prior to sleep
( ) I frequently travel across 2 or more time zones
( ) I drink alcohol prior to bedtime
( ) I smoke prior to bedtime or when I awaken during the night
( ) I eat a snack at bedtime
( ) I typically awaken to urinate during the night. How often? _____
( ) I have trouble falling asleep
( ) I awaken frequently during the night
( ) I am unable to return to sleep easily if I awaken during the night
( ) Thoughts start racing through my mind when I try and fall asleep
( ) I have nightmares as an adult
( ) I experience a creeping-crawling or tingling sensation in my legs when I try and fall asleep

( ) I sweat a great deal during sleep
( ) I cannot sleep on my back

Breathing

( ) I have been told I stop breathing while asleep
( ) I awaken at night choking, smothering or gasping for air
( ) I have been told I snore
( ) I have been told I snore only when sleeping on my back
( ) I have been awakened by my own snoring

Review of Systems : Please place a mark between ( ) if symptom present.
Constitutional: Positive for activity change. Negative for fever, chills, diaphoresis, appetite change, fatigue and unexpected weight change.
HENT: ( )mouth sores ,( ) congestion, ( ) drooling, ( ) ear discharge, ( ) ear pain, ( )facial swelling, ( ) hearing loss, ( ) postnasal drip, ( ) sinus pressure ,( ) sneezing , ( )sore throat, ( ) tinnitus.
Eyes: ( )photophobia, pain, ( ) discharge, ( )redness, ( ) itching, ( )visual disturbance.
Respiratory: ( )cough, ( ) choking, ( ) chest tightness, ( )wheezing.
Cardiovascular: ( )chest pain, ( ) palpitations, ( )leg swelling.
Gastrointestinal: ( )nausea, ( ) vomiting, ( ) abdominal pain, ( ) diarrhea, ( ) constipation, ( )abdominal distention.
Endocrine: ( ) cold intolerance, ( ) heat intolerance, ( ) polydipsia, ( ) polyuria.
Genitourinary: ( ) urgency, ( ) dysuria, ( )hematuria, ( ) difficulty urinating.
Musculoskeletal: ( )neck pain, ( ) back pain, ( ) joint swelling, ( )arthralgia, ( ) gait problem.
Skin: ( ) color change, ( ) pallor, ( ) rash.
Allergic/Immunologic: ( ) environmental allergies, ( ) food allergies, ( ) immunocompromised state.
Neurological: ( ) dizziness, tremors, ( )seizures, syncope, ( ) facial asymmetry, ( )numbness, ( ) headaches.
Hematological: ( ) adenopathy, ( ) bruise/bleed easily.
Psychiatric/ Behavioral**:** ( )hallucinations, ( ) confusion, ( ) sleep disturbance, ( )agitation.

Consent to the Use and Disclosure of Health Information

For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a company of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent to writing except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____ Date: _____

Signature of Patient or Legal Representative

_____ Date: _____

Signature of Witness

Consent for Positive Airway Pressure Treatment

I, _____,(the patient or legal guardian) do consent to the testing and treatment associated with polysomnography, including CPAP and/or bi-level, ASV or AVAP as prescribed by my treating physician, I hereby authorize the Wyoming Sleep Disorders Center to provide medical diagnostic care by the standards set forth by the American Academy of Sleep Medicine. I have had the procedure explained to me and given the opportunity to ask questions.

I also acknowledge that I am financially responsible for medical testing & treatment i.e., deductibles, co-pays, non-covered treatment or testing that I have agreed to, etc, & that if I am experiencing difficulty meeting my obligations it is my responsibility to notify the sleep center's billing department to make reasonable payment arrangements.

Patient Printed Name: _____

Patient/Guardian Signature: _____ Date: _____

Relationship if Guardian: _____

CONSENT FOR PATIENT PHOTOGRAPHY

Name: _____ DOB: _____

I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this. I hereby give my consent to have a photograph/ photographs, videotape, digital or other images taken during my sleep study.

I understand that Wyoming Sleep Disorders Center will retain ownership rights to these photographs, videotape, digital or other images, but that I will be allowed to access to view them I understand that these images will be stored in a secure manner that will protect my privacy. Images that identify me will be released and/or used outside the facility only upon written authorization from me or my legal representative.

This consent does not authorize the use of images for other purposes such as teaching or publicity.

_____

Signature of Patient or Legal Representative

_____

Signature of Witness

If phone consent is obtained, second witness is required

_____

Signature of Second Witness

Important Sleep Study Information:

1. Check- in time is 8:30 PM. Please try to avoid being here any earlier than 8:15, unless prior arrangements are made.
2. Your technician will wake you up between 5 and 6 the following morning.
3. The doors will be locked when you get here, so please ring the buzzer on the **LEFT** hand side of the door, and the technician will ring you in.
4. No excessive lotion, hairspray, hair conditioner, or makeup, etc.
5. You will have a private room with a private shower; we will provide towels, and washcloths. Please bring your own toiletries and any personal hygiene items you may need.
6. Medication(s): You may bring the medication(s) you use in the evening and early morning which you may take as prescribed by your provider.
7. There is a TV in your private room, but if you wish to read, please bring you own reading material or any other routine nighttime material.
8. No caffeine after 8:00AM on the day of your sleep study.
9. If you have a CPAP machine now, you may bring your mask if you wish, although we will be fitting you for one at you sleep study.
10. All minors must be accompanied by a parent or guardian.
11. If you are out of town, we do provide extra rooms for spouses/family members for you convenience.
12. We are a smoke free facility.