ALASKA SLEEP CLINIC
an ALYESKA INTERNATIONAL, INC. company

Anchorage
3920 Lake Otis Pkwy., Ste.101
Anchorage, AK 99508
P: 907.770.9104
F: 907.770.8965

Fairbanks
1901 Airport Way, Ste. 101
Fairbanks, AK 99701
P: 907.374.3063
F: 907.374.8872

Soldotna
588 Pace Street
Soldotna, AK 99669
P: 907.420.0540
F: 907.420.0541

Wasilla
1051 East Bogard Rd., Ste. 1
Wasilla, AK 99654
P: 907.357.6700
F: 907.357.6672

Patient Registration Form

Patient Information:

Patient Last Name:_____ First Name:_____ DOB:_____ Sex:____

Mailing Address:_____ City:_____ State/Zip:_____

Home / Cell Phone: _____ Work Phone: _____ Marital Status:_____

Email address: _____ Occupation: _____

Emergency Contact Name:_____ Relationship to Patient: _____

Emergency Contact Telephone Number: _____

Physician Name:_____ Physician Telephone Number_____

Primary Insurance Information:

Insurance Carrier:_____ ID Number:_____ Group Number:_____

Claims Mailing Address:_____ City:_____ State/Zip:_____

Relationship to Insured: Self ☐ Spouse ☐ Other:_____

Secondary Insurance Information:

Insurance Carrier:_____ ID Number:_____ Group Number:_____

Claims Mailing Address:_____ City:_____ State/Zip:_____

Relationship to Insured: Self ☐ Spouse ☐ Other:_____

Authorizations to Release Medical Information, Claim Payments, and Insurance Verifications:

—— I authorize the Alaska Sleep Clinic to furnish any information and records regarding the services provided to me, including information regarding psychiatric, substance abuse and communicable diseases as follows:

a) to any person or corporation that I indicate is responsible for paying my health care bills or that may be liable under contract with me to pay my health care bills, and b) Health care providers have access to my health care records as needed for the purposes of continuity of care.

—— I hereby authorize the Alaska Sleep Clinic to release any information regarding services rendered by them and to allow a photocopy of my signature to be used to file my Medicare and/or insurance claim, and any third party payor.

—— I hereby authorize the Alaska Sleep Clinic to bill my insurance carrier and receive payment for services on my behalf. By signing below I am verifying the personal data on this sheet is accurate and indicating I understand the information provided.

Patient Signature: _____ Date: _____

SLEEP DIARY

ALASKA SLEEP CLINIC
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	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
What time did you go to bed?							
What time did you wake up?							
How well did you sleep?							
At what times, if any, did you wake during the night?							
What and when did you eat or drink before bed?							
Rank the day's stress level from 1 to 10							
Note any drugs, medications, or alcohol before bed							

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Financial Policy

Patient Last Name:_____First Name:_____DOB:_____

The Alaska Sleep Clinic (ASC) believes that part of good health care practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy. Please note that this form MUST BE COMPLETED ANNUALLY.

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. If you are unable to meet this obligation at the time of service you must make payment arrangements prior to receiving service and/or supplies. We do ask for a copy of an ID card or license due to the many cases of identity theft in the news lately. (Please do not be offended!)
2. INSURANCE We are participating providers with many insurance plans. We will file all insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If you are insured by a plan with which we have no prior arrangement, we will still prepare and send the claim in for you. If you receive payment for a service or supply furnished by our office you are expected to make payment to ASC immediately. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.
3. RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving and further services or supplies from the ASC. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action.
4. ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service
5. BILLING OFFICE: If you have questions in regard to any of your billing statements, our accounts receivable staff is available to assist you. CALL 907.357.6700.
6. RESPONSIBILITY FOR PAYMENT: You understand that you, personally, are financially responsible to the Alaska Sleep Clinic for charges not covered by the assignment of insurance benefits.
7. DME SUPPLY LIMITATIONS: You understand that if you have benefits through a federally funded insurance plan, and the ASC provided and billed for a sleep study on your behalf, then ASC is not authorized to provide Durable Medical Equipment to you. These insurances include Medicare, Medicaid, TriCare and Veterans Administration. If you are eligible for the above stated benefits ASC will assist you in locating a suppliers who can meet your Durable Medical Equipment needs. You must notify ASC in writing immediately if you become eligible for one of these payers.
8. INTERPRETATION FEES: You understand that Sleep Studies performed by ASC are interpreted by a qualified Sleep Medicine Specialist. You will receive a separate billing for this service. Payment should be made directly to the interpreting physician for this service. Your signature below confirms that you understand the above Financial Policy and agree to abide by its terms.

The signing of this Financial Policy is a prerequisite to receiving any service or supply from ASC. Your signature below confirms that you have read and understand the above financial policy and agree to abide by its terms. The signing of this Financial Policy is a prerequisite to receiving any service or supply from ASC.

Patient Signature: _____ Date: _____

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Authorization for Release of Confidential Health Information

PATIENT NAME:	PATIENT DATE OF BIRTH:
ADDRESS:	PHONE:
CITY, SATE, ZIP:	

***** REQUESTOR MUST PROVIDE A LEGIBLE COPY OF LEGAL IDENTIFICATION WITH THIS FORM *****

INFORMATION IS TO BE DISCLOSED BY:		AND IS TO BE RELEASED TO:	
AGENCY NAME:		NAME OF INDIVIDUAL RECEIVING RECORDS:	
ADDRESS:		AGENCY NAME:	
CITY, SATE, ZIP:		ADDRESS:	
PHONE:	FAX:	PHONE:	FAX:

◯ I authorize the communication to be exchanged in/by: ◯ Writing ◯ Verbally ◯ Fax

◯ I authorize the use/disclosure of health information about the above name individual/entity as described below for the following dates and purposes.

◯ Dates of information: from _____ to _____

- ◯ Only information related to (Specify injury, accident or particular illness / treatment: _____
- ◯ Entire record for all dates of service.
- ◯ Billing statements for the following dates/treatment: _____
- ◯ Other information specified below:
  - ◯ Medical Records
  - ◯ Lab / Pathology Reports
  - ◯ Diagnosis
  - ◯ Medication list
  - ◯ Psychological/Psychiatric Assessment
  - ◯ Substance Abuse Assessment
  - ◯ Mental Health Assessment
  - ◯ Study Summary, Plan, Status

The information will be disclosed for the following purposes:

- ◯ Attorney ◯ Insurance ◯ Disability ◯ Military
- ◯ Customer Transferring Care to Other Hospital/Clinic ◯ At request of the individual or Personal Representative

I understand that my records are protected under HIPAA and may also be further protected under 42 CFR, Part 2(substance abuse diagnosis or treatment related records). I understand these records cannot be disclosed without my written consent, unless otherwise provided for by law, and that in most cases cannot condition my treatment, enrollment in a health plan, or eligibility for health care benefits on my failure to sign the authorization. I am aware that, but for records protected under 42 CFR Part 2, there is a potential that records disclosed under this authorization are subject to re-disclosure and are no longer protected under HIPAA. I am aware that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires:

_____One year from the date signed, or on: _____.

This information has been disclosed to you from records protected by Federal Confidentiality Rules, including HIPAA and potentially 42 CFR Part 2). If these records are governed by 42 CFR Part 2, you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains to or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Patient Signature _____ Date _____

Verification of Identity and Authority

Date Received: _____ Form of Identification _____ :Received by: _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Alaska Sleep Clinic (ASC) is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. ASC is also required to abide by the terms of the version of this Notice currently in effect.

Uses and Disclosures of PHI: ASC may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

- For treatment. This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI via radio or telephone to the hospital or dispatch center.
- For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts.
- For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions. Reminders for Scheduled Appointments and Information on Other Services. We may also contact you to provide you with a reminder of any scheduled appointments or to provider information about other services we provide.

Use and Disclosure of PHI without Your Authorization: ASC is permitted to use PHI *without* your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including:

- For the treatment, payment or health care operations activities of another health care provider who treats you;
- For health care and legal compliance activities; • To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests;
- To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence)
- For health oversight activities including audits or government investigations,
- inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when responding to a warrant;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals;
- We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are.

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Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

***Patient Rights**:* As a patient, you have a number of rights with respect to your PHI, including:
The right to access copy or inspect your PHI. This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights.
You also have the right to receive confidential communications of your PHI. If you wish to inspect and copy your medical information, you should contact our privacy officer.

The right to amend your PHI. You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request that we amend the medical information that we have about you, you should contact our privacy officer.

The right to request an accounting. You may request an accounting from us of certain disclosures of your medical information that we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, like our billing company or our Medical Director who interprets your study results. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting, contact our privacy officer.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you. ASC is not required to agree to any restrictions you request, but any restrictions agreed to by ASC in writing are binding on ASC.

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request. If we maintain a web site, we will prominently post a copy of this Notice on our web site. If you allow us, we will forward you this. Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice: ASC reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting our privacy officer.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to our privacy officer.

Privacy Officer Contact Information:
Faith Allard
Executive Director
Alaska Sleep Clinic

Effective Date of this Notice: June 30, 2017

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Information and Patient Releases

Initial below indication your understanding and release:

_____ In order to collect a complete and detailed sleep study that will enable the physician(s) providing my care to effectively diagnose and treat my sleep condition, I, the undersigned, consent and authorize photographic, video, and/or audio data to be recorded during the testing procedure.

_____ I further authorize the subsequent use of my photographic, video, and/or audio recording to be used for the furtherance of medial science and/or for medical education purposes. I consent to the presentation of all relevant medical information and clinical demonstration concerning my/this case to students of medicine and allied health sciences, to medical professional groups, and to the possible publication thereof in scientific literature. Anonymity will be insured.

_____ Sleepiness causes auto crashes because it impairs your reaction time and attention and ultimately can lead to you falling asleep at the wheel. Although no driver is immune to drowsy driving-related accidents, there are higher risks to some populations. People with untreated sleep apnea, narcolepsy or other sleep disorders are at higher risk for driving-related accidents.
Upon completion of a physician directed sleep disorders test performed at **Alaska Sleep Clinic** you have been provided written explanation of the consequences and are hereby advised against driving until such time as you have been evaluated, diagnosed and successfully treated by a physician for any sleep disorder that can impair your ability to safely operate a motor vehicle, and until such time as all symptoms of excessive sleepiness have been successfully resolved.

My signature below confirms I have read and understand the above paragraphs. My initials above indicate my consent to and/or acknowledge the information presented.

Signature: _____

Date: _____

Witness to Signature: _____

Date: _____

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Acknowledgement:

The department of Health and Human Services has established a "Privacy Act" to help insure that personal health care information is protected for privacy. The Privacy Act was also created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient and/or carry out treatment, payment or health care operations (TPO).

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide services that are in your best interest.

I acknowledge that I have received, or had the opportunity to receive, a full copy of my full rights regarding my personal health information. I understand that I can obtain an additional copy of these rights from this office or on the Alaska Sleep Clinic website (www.alaskasleep.com) at any time.

I have reviewed and understand my rights regarding my personal healthcare information.

Signature: _____ Date: _____

Printed name: _____

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Patient Questionnaire

Patient Information:

Patient Last Name:_____ First Name:_____ DOB:_____ Sex:____

Age:_____ Weight:_____ Height:_____ Marital Status:_____

Mailing Address:_____ City:_____ State/Zip:_____

Home / Cell Phone: _____ Work Phone: _____ Referring Physician:_____

Please describe why you need a sleep study at this time:

_____

_____

_____

_____

Sleep Schedule

1. What time on weekdays do you usually — Go to bed? _____ Wake up? _____
2. What are your usual working hours if applicable — Begin? _____ End? _____
3. What time on weekends do you usually — Go to bed? _____ Wake up? _____
4. On average, how long do you actually sleep at night? — Weekdays? _____ Weekends? _____
5. Do you feel you get too much or too little sleep at night? — Too much? _____ Too little? _____

Nighttime Symptoms

6	How long does it normally take you to fall asleep at night?	Minutes	_____			
7	Do you have thoughts that prevent sleep?	_____	Yes	_____	No	
8	Do you have trouble getting to sleep at night?	_____	Yes	_____	No	
9	Do you awaken at night to use the bathroom?	_____	Yes	_____	No	How often? _____
10	Are you ever awakened by a "coughing spell" during the night?	_____	Yes	_____	No	
11	Do you have crawling sensation in your legs when falling asleep?	_____	Yes	_____	No	
12	Do you have twitching movements in your legs during the night?	_____	Yes	_____	No	
13	Do you awaken with racing thoughts, sadness or anxiety?	_____	Yes	_____	No	
14	Have other people told you that you have restless sleep?	_____	Yes	_____	No	
15	Do you have difficulty going back to sleep during the night?	_____	Yes	_____	No	
16	Does anyone tell you, you snore badly?	_____	Yes	_____	No	
17	Do you have difficulty breathing at night?	_____	Yes	_____	No	
18	Do you wake up with headaches?	_____	Yes	_____	No	How often? _____
19	Do you awaken with a sour or bitter taste in your mouth?	_____	Yes	_____	No	
20	Is it difficult for you to awaken & get out of bed after sleeping?	_____	Yes	_____	No	

21 Have you experienced paralysis upon awakening from sleep? ____ Yes ____ No

22 Do you have vivid dreams as you are falling asleep? ____ Yes ____ No

23 Is your sleep disturbed by a medical problem? ____ Yes ____ No How often? ____

Daytime Symptoms

24 Do you deliberately take naps during the day? ___ Yes ___ No How often? ___ How Long? ____

25 Do you feel rested or refreshed after a nap? ___ Yes ___ No

26 Are you bothered by sleepiness during the day? ___ Yes ___ No How often? ___

27 Do you find yourself falling asleep when you don't mean to? ___ Yes ___ No How often? ___

28 Do you take naps during the day? ___ Yes ___ No I want to but can't ___ Number of times per week? ____

29 Do you fall asleep during these situations?

0 = no chance of dozing, 1 = slight chance of dozing, 2 = moderate chance of dozing, 3 = high chance of dozing

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place?	0	1	2	3
As a passenger in a car for an hour with out a break	0	1	2	3
Lying down to rest in afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total of all answers: ____

30. Have you ever had the following kinds of weakness develop suddenly during an emotional situation? (for example, when laughing, if angry, if in an exciting situation, etc.)?

Knees buckling	Never	1-5 times in your life	Monthly	Weekly	Daily	Almost daily
Mouth opening	Never	1-5 times in your life	Monthly	Weekly	Daily	Almost daily
Head nodding	Never	1-5 times in your life	Monthly	Weekly	Daily	Almost daily
Falling down	Never	1-5 times in your life	Monthly	Weekly	Daily	Almost daily

31. Do you know, or others tell you that you:

	Age Started	Last Occurred	Frequency	Treatment
Talk while apparently asleep?				
Walk while apparently asleep?				
Grit teeth while apparently asleep?				
Wake up screaming, anxious or afraid?				
Have disturbing dreams (nightmares)?				
Have unusual movements while asleep?				

32. Health history. Please mark all that apply.

___ Weight Problems	___ Tonsillectomy	___ Lung Disease	___ Heart Disease	___ Stroke
___ High blood pressure	___ Sinus Surgery	___ Ulcers	___ Neurologic Disease	___ Cancer
___ Shortness of breath	___ Chronic Cough	___ Colitis	___ Anxiety	___ Narcolepsy
___ Deviated nasal septum	___ Chronic Bronchitis	___ Kidney problems	___ Dementia	___ Chronic Fatigue
___ Sinus Problems	___ Asthma	___ Thyroid Disorder	___ Depression	___ Fibromyalgia
___ Emphysema	___ Diabetes	___ Psychiatric	___	___ Parkinson's

33. Please list any other health or surgical history:

34. Does anyone in your family have sleep problems?

Relationship to you:	Problem:

35. For each of the beverages below, please write the average amount that you drink per day:

Regular Coffee (cups)		Hot or Iced Tea (cups)		Caffeinated Drinks	

36. Do you smoke cigarettes? _____Yes _____No

If yes, how many packs per day? _____ For how may years?_____

If no, did you ever smoke? _____Yes _____No When did you stop?_____

37. How many alcoholic beverages do you drink per day during the week? _____ per month? _____

Medications - Please list your current medications below:

Medication	Amount/Dose	How Often	Years	Reason

Additional Information:

38. If there are any other aspects of your sleep that you feel are important, please describe them below:

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Prior Sleep Study History

Patient Name: _____ Date of Birth: _____

Please describe why you need a sleep study at this time:

_____

_____

_____

_____

Have you ever had a sleep study in the past? ____Yes ____No

If you answered **NO**, ignore this page. If **YES**, please provide a copy of your sleep study records. Please bring your current Positive Airway Pressure Machine (CPAP, APAP, BiLevel, ASV) machine and mask if applicable, and answer the following questions:

When was your previous sleep study? _____

Where was your previous sleep study conducted? _____

What were the study results? _____

Are you currently using Positive Airway Pressure Machine (CPAP, APAP, BiLevel, ASV) machine? ____Yes ____No

If yes, what is your treatment setting? _____

Please indicate the make, model and age of your machine:

Make: _____

Model: _____

Age: _____

Do you expect to be replacing your machine? ____Yes ____No

Please indicate the name, size and age of the mask that you are using:

Name: _____ Size: _____ Age: _____

ALASKA SLEEP CLINIC
an ALYESKA INTERNATIONAL, INC. company

Anchorage
3920 Lake Otis Pkwy., Ste.101
Anchorage, AK 99508
P: 907.770.9104
F: 907.770.8965

Fairbanks
1901 Airport Way, Ste. 101
Fairbanks, AK 99701
P: 907.374.3063
F: 907.374.8872

Soldotna
588 Pace Street
Soldotna, AK 99669
P: 907.420.0540
F: 907.420.0541

Wasilla
1051 East Bogard Rd., Ste. 1
Wasilla, AK 99654
P: 907.357.6700
F: 907.357.6672

Bed Partner Questionnaire

This form is to be completed by the patient's bed partner, if applicable.

Patient Last Name:_____First Name:_____DOB:_____

Person completing the form (Last name, first name):_____

Relationship to patient:_____

1. I have observed this person's sleep (select one): _____Never_____ 1 or 2 times _____ Often _____Every Night
2. Check the following behaviors that you have observed:

☐ Light snorer	☐ Sleep Talking	☐ Grinding teeth
☐ Moderate snorer	☐ Bed-wetting	☐ Sitting up in bed not awake
☐ Loud snorer	☐ Awakening with pain	☐ Head rocking or banging
☐ Occasional loud snorts	☐ Getting out of bed not awake	☐ Biting tongue
☐ Choking	☐ Become very rigid and shaking	☐ Crying out
☐ Pauses in Breathing	☐ Twitching or kicking legs	☐ Other

3. If this person snores, what makes it worse?

_____ Sleeping on his/her back

_____ Sleeping on his/her side

_____ Fatigue

_____ Alcohol consumption

4. Please describe the behaviors checked above in more detail. Describe the time when it occurs, how often it occurs during the night, and whether it occurs every night.

_____

_____

5. Has this person fallen asleep during normal daytime activities or in dangerous situations? _____ Yes _____ No

   If yes, please explain: _____

_____

6. Does this person use sleeping pills? _____ Yes _____ No What kind? _____ How often? _____

7. Does this person drink alcohol? _____ Yes _____ No If yes, how many drinks per week of the following:
   _____12 oz. Beer _____ 6 – 8 oz. Glasses of wine _____ 1 – ½ oz. of hard liquor

8. Please estimate how much alcohol this person consumes in the 3 hours before bed: _____

9. If this person uses recreational drug, please describe both the types and frequency of usage:
   Type: _____ Frequency: _____
   Type: _____ Frequency: _____

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New Patient Appointment

Appointment Date / Time:

You are scheduled for a sleep study on: _____ at _____ PM

Your appointment will be at the following location: Wasilla (1051 East Bogard Rd., Ste 1)

Instructions for the day / night of your appointment:

DO

- ✓ Do bring your regular prescribed medications to take according to your physician's instructions
- ✓ Do bring sleeping clothes, such as pajamas or shorts and t-shirt
- ✓ Do bathe and have your evening meal PRIOR to coming to the sleep clinic
- ✓ Do bring a favorite pillow or blanket if desired
- ✓ Do bring reading material if desired

DO NOT

- ✓ Do not take any naps during the day prior to your study
- ✓ Do not drink or eat anything containing caffeine
  - o such as coffee, chocolate, tea, soda, etc. after 11:00am the day / night of the study
- ✓ Do not use hairspray, leave-in conditioner or hair oils the day / night of the study

What to expect when you arrive for your sleep study:

When you arrive at the clinic, a sleep technologist will explain the testing procedure and answer any questions that you may have about the procedure. You will be escorted to a private room where you will sleep and the study will be conducted. The Technologist will apply several sensors on your body to record brain activity, eye movements, muscle movements, heart rate, and other parameters. All of the sensors are completely non-invasive and painless. The Technologist will be in the clinic and available to you throughout testing to provide for your safety and to monitor the recording of the study. A minimum of six hours of recording time is necessary to get a complete study.

No electronic items such as radios, TVs, cell phones, etc. are allowed to be used once the study has begun. Electronic items interfere with the equipment and may cause artifact in the electrodes.

What to expect when you wake up:

When you wake up from the sleep study the Technologist will wake you and remove the electrodes and sensors. You will be provided an opportunity to clean up and given a washcloth and towel. Don't worry if all of the application paste does not come out of your hair, it is easily removed during a full shower with soap and water.

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STOP BANG Questionnaire

Patient Last Name:_____First Name:_____DOB:_____

1. Snoring: Do you snore loudly (loud enough to be heard through a closed door)? _____ Yes _____No
2. Tired: Do you often feel tired, fatigued, or sleepy during the daytime? _____ Yes _____No
3. Observed: Has anyone observed you stop breathing during your sleep? _____ Yes _____No
4. Blood pressure: Do you have or are you being treated for high blood pressure? _____ Yes _____No
5. BMI: Is your Body Mass Index more than 35 kg/m2? _____ Yes _____No
6. Age: Are you over 50 years of age? _____ Yes _____No
7. Neck circumference: Is your neck circumference greater than 40cm? _____ Yes _____No
8. Gender: _____ Male _____ Female

- Neck circumference is measured by staff.
- High Risk of OSA: Answering yes to three or more questions
- Low Risk of OSA: Answering yes to less than three questions.