HomeSleep,LLC

Patient Instructions

Name of Patient: _____

1. You are being provided with a home sleep test that you can perform in the comfort of your home.

2. The test will only take one night. Please perform the test within **three (3) days** of receiving your device.

3. To avoid equipment charges, please ship this device back no later than **four (4) days** of receiving this device.

4. A Board Certified Sleep Physician will interpret your test results.

5. Please call Home**Sleep** with ANY questions between Monday through Friday 8:00 am to midnight and Saturday from noon to 4:00 PM.

6. You have been given verbal and written instructions on how to perform this home sleep test

7. **This sheet must be returned with your device.**

Date: _____

Patient: _____ Signature: _____

HomeSleep, LLC

Helpful Tips for a Successful One Night Home Sleep Test

- **Men**: Please place the belt across the chest.
  Women: Please place the belt underneath the breast area.

- Once the batteries are placed in the unit correctly and the belt is securely clicked into the unit on each side the unit will automatically turn on.

- You will know that the unit has turned on automatically once you see the lights at the top of the unit start to blink. If the lights do not appear once you set up the unit, please check the batteries and be sure the belt is clipped in on both sides. Adjust the belt so the unit can detect that is secure around your sternum area.

- You will see three green sensor lights: one for the respiratory effort belt, one for the nasal cannula, and one for the pulse ox sensor. The lights will shut off after a few minutes. This means the unit has started recording.

- If one of the sensor lights turns yellow, this means that you will need to adjust the sensor that corresponds with the yellow light. Once you have adjusted the sensor, the corresponding light will turn green and then turn off again.

- Please use the surgical tape provided to hold the sensors in place.

- **DO NOT PRESS ANY BUTTONS.** It will disrupt the test.

- Once test is completed, the unit will turn off automatically. Please leave the batteries inside of the unit, place unit "as is" inside of the box and complete the patient paperwork that came with the unit.

- Place the prepaid return label that has been provided to you on the box and return the unit to your nearest post office.

Tel: 201.967.1111 ○ Fax: 855.967.1112 ○ www.HomeSleepLLC.com

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have been given the opportunity to receive a copy of your Notice of Privacy Practices at www.homesleepllc.com or by calling Home**Sleep** at (888) 425-8988.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

HIPAA Privacy Rule

Provided by AAPC Physician Services

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Epworth Sleepiness Scale

Name: _____ Date: _____

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

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

0 = would never doze or sleep

1 = *slight* chance of dozing or sleeping

2 = *moderate* chance of dozing or sleeping

3 = *high* chance of dozing or sleeping

Situation	Chance of dozing or sleeping
1. Sitting and Reading.	
2. Watching TV.	
3. Sitting inactive in a public place.	
4. Being a passenger in a motor vehicle for an hour or more.	
5. Lying down in the afternoon.	
6. Sitting and talking to someone.	
7. Sitting quietly after lunch (no alcohol).	
8. Stopped for a few minutes in traffic while driving.	
Total Score (This is your Epworth score):	

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Patient Questionnaire

Patient Name: _____ Date: _____

Sex: ❑ F ❑ M Age: Height: Weight: Neck Size in inches (if known):

Past Sleep Evaluation and Treatment

❑ I have had a previous sleep disorder evaluation
❑ I have had a previous overnight in-lab or home sleep study
If Yes, Name of Center:
Year:
Results (if known):
❑ I have previously been prescribed a CPAP, AutoPAP or BiPAP machine for home use
❑ I currently use a prescribed CPAP, AutoPAP or BiPAP machine
❑ I have had surgery to treat snoring or sleep apnea
❑ I have used a dental appliance to treat snoring or sleep apnea

Breathing & Sleep

❑ I have been told that I snore
❑ I have been told that I snore only when sleeping on my back
❑ I have been awakened by my own snoring
❑ I have been told that I stop breathing while I sleep
❑ I have woken up at night choking or gasping for air
❑ I often wake up with a dry mouth
❑ I often wake up with headaches
❑ I often have to use the bathroom more than once during the night
❑ I grind my teeth in my sleep. If yes, do you wear a mouth guard? ❑ Yes ❑ No
❑ I often experience symptoms of acid reflux or "heartburn"

Daytime Sleepiness

❑ I often find my sleep to be unrefreshing
❑ I often feel tired or not up to par during the day
❑ I have problems with attention, concentration or memory during the day
❑ I perform poorly at work or school because of sleepiness
❑ I have fallen asleep while driving
❑ I have had auto accidents as a result of falling asleep while driving
❑ I have been injured as a result of sleepiness

Habits

Do you smoke? ❑ Yes ❑ No
If Yes: Amount smoke per Day:
For How Many Years:
Do you drink alcoholic beverages? ❑ Yes ❑ No
If Yes: What types of beverage(s): Wine Beer Liquor
Total drinks per Week:
Recreational substance use? ❑ Yes ❑ No
Please specify:

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Patient Questionnaire

Medical History

List all your Medical Conditions and Year Diagnosed

Surgeries

Tonsillectomy ❑ Yes ❑ No Year:
Adenoidectomy ❑ Yes ❑ No Year:
Weight loss surgery ❑ Yes ❑ No Year:

List all other Surgeries and the Year:

Current Medications (prescription and over the counter)

Medication	Dose	Times per Day	Reason Taken