Nevada Sleep Diagnostics

The Joint Commission

•Joint Commission Accredited to Perform Medicare, NV Medicaid, HPN Medicaid and Tricare Military Sleep Studies•

You have been scheduled for an overnight sleep study at our facility. The following important information is attached:

1. General Instructions,
2. Medical Fact Sheet,
3. Driving Directions, and
4. The Patient Sleep Questionnaire.*

Please complete the Patient Sleep Questionnaire and bring it with you to your appointment. This is an important tool for our sleep medicine physician to better diagnose your specific condition.

IMPORTANT INFORMATION

- ***Confirmation of your appointment is required***. Our office will contact you two days in advance to verify confirmation. The deadline for confirmation of appointments is listed below:

If Your Appointment is On:	The Deadline to Confirm is:
Tuesday-Friday	5:00 p.m. the Day Prior to Your Appointment
Saturday, Sunday, or Monday	5:00 p.m. on the Thursday Prior to Your Appointment

- **It is important that you confirm your appointment as we have reserved a bed for you. If you do not reschedule prior to the confirmation time or do not show for your appointment you will be charged a $100 cancellation fee.**
- **PLEASE NOTE**: **As our sleep technicians do not arrive at the lab until 8:00 p.m., the facility is not open until that time.**

If you have any questions about the information in this Patient Packet, please do not hesitate to call our office. We will be glad to assist you in any way possible.

Thank you for the opportunity to serve your health care needs. We look forward to providing you with the highest level of professional and quality care.

FOR ALL INQUIRIES, PLEASE CALL (702) 990-7660

Please bring exact amount of co-pay or deductible

GENERAL INSTRUCTIONS

Please review the following information carefully. If you have any questions, please do not hesitate to contact our office at (702) 990-7660.

When Should I Arrive for My Appointment?

You need not arrive any earlier than 10 minutes before your appointment, as the preparation time for the test will occur upon your arrival. It is important that you be on time, as patients are scheduled every 15 minutes.

When Will I be Released the Next Morning?

You will be released between 5:00 a.m. and 5:30 a.m. The overnight sleep study is non-invasive, so you may drive yourself. However, if you have excessive daytime sleepiness, we caution you on driving.

What is an Overnight Sleep Study?

A Polysomnogram (PSG) is a diagnostic recording of physical activities that occur while you sleep. These activities are monitored and recorded through the use of electrodes and sensors. The sleep test will measure the amount of sleep and quality of sleep. The following functions are monitored and recorded:

- ✓ Oxygen saturation levels.
- ✓ Respiration.
- ✓ Electroencephalography (EEG): Measures electrical activity of the brain.
- ✓ Electrocardiogram (EKG): Measures electrical activity of the heart.
- ✓ Leg Electromyography (EMG): Measures activation signals of the muscles.
- ✓ Abdominal effort.

What is the Preparation for the Sleep Study?

The sleep technician will paste and secure electrodes to your head, neck, and legs. The electrodes will remain on for the entire night. A finger pulse oximeter will be attached to your index finger and will be used to measure the amount of oxygen in your blood. In addition, a respiratory belt will be placed around your abdomen. The electrodes are attached to leads that are inserted into the equipment in each bedroom. However, the leads do allow for movement, and you are able to use the restroom during the night, if necessary.

Where Will I Sleep?

You will have your own private bedroom with a door. At Nevada Sleep Diagnostics, we strive to create the most comfortable sleeping environment possible. We do provide fresh pillows and linens. However, you are welcome to bring your own pillow if you feel more comfortable. There is enough room on the night stand if you wish to have water during the night. Unless there is a medical necessity, you will not be disturbed during the night.

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How Do I Prepare?

- If you require special assistance getting in and out of bed, moving from the bed to the restroom, or changing clothes, you will be required to bring a caregiver to stay with you throughout the night. Please notify our office in advance of this need to ensure that your caregiver has a place to sleep.
- You may bring your sleepwear to the facility and change clothes in your bedroom or in the restroom. Please do not wear satin or silky garments, as the respiratory belt will not stay in place during the night. ***Two-piece pajamas or shorts and a t-shirt are preferred.*** All patients must wear sleep clothing, and will not be permitted to sleep in their undergarments. Other patients will be in the facility, and everyone must remain appropriately dressed for their entire stay. Please bring **slippers**.
- Please bring all medications that you take at or near bedtime. If your physician has asked you to take a sleep aide, please bring it with you. The technician will instruct you when it is a good time to take the sleep aide. We do not recommend taking sleep aides for the study. However, if you must, please do not take them until the sleep technician asks you to do so. Continue to take all prescribed medications at your regularly-scheduled times, unless your physician instructs you differently for this test.
- Please bathe or shower on the day of the study. Please do not use body lotion, as excess oils on the skin will prevent the adhesive from sticking to the skin. Hairsprays, gels, mousses, and conditioner will also prevent the electrodes from sticking to the scalp, so please do not use them. Please make sure that your hair is dry prior to your arrival. Please do not use nail polish, as it interferes with the pulse oximeter's infrared technology, and we will be unable to determine correct blood oxygen levels.
- Please refrain from using alcohol or other controlled substances before your study, unless instructed to do so by your physician. Please refrain from ingesting any caffeinated products after 12:00 noon on the day of your study.
- You are welcome to bring personal toiletry items that you may need prior to bedtime or upon waking the next morning. We do have bathrooms at the lab but do not have showers.

When Will I Know the Results of My Test?

- Your test results will be interpreted by one of our board-certified sleep medicine physicians. The results will be faxed to your doctor within five to ten business days after your appointment. Your physician will discuss the results and treatment options. You may need to schedule a follow-up appointment with your doctor, if you do not already have one.
- Please note that the sleep technician is not permitted to discuss the results of your study in the morning, as the results have not yet been evaluated.

If You Have Questions

- Our experienced staff is prepared to answer any questions you may have about your overnight sleep study. Please do not hesitate to contact us at any time.

FOR ALL INQUIRIES, PLEASE CALL (702) 990-7660

Patient Name:_____ **Today's Date:**_____

Address_____**City**_____**State**_____**Zip**_____

E-Mail: _____ **Home/ Cell Phone** _____

DOB___/___/___ **Marital Status: S M D W** _____ _____
IF PT IS A CHILD, WHO MAY AUTHORIZE TREATMENT? RELATIONSHIP

Emergency Contact Name: _____**Phone** _____

Employer Name:_____ **Phone** _____

Address_____**City**_____**State**____**Zip**_____

Job Title: _____

Do you have insurance? ☐ **Yes** ☐ **No If no, how will you be paying?** ☐ **Cash** ☐ **Check** ☐ **Credit**

PRIMARY INSURANCE **(Insurance companies require the below information for billing purposes)**

Name of Insured_____ **Relationship to Pt**_____

Insured's SSN_____-_____-_____ **Insured's DOB**_____/_____/_____

Insurance Co. Name_____ **Phone#** _____

Address_____ **City** _____**State** _____ **Zip**_____

Policy#_____**GroupID:**_____

SECONDARY INSURANCE

Name of Insured_____ **Relationship to Pt:**_____

Insured's SSN_____-_____-_____ **Insured's DOB**_____/_____/_____

Insurance Co. Name_____ **Phone#** _____

Address_____ **City** _____**State** _____ **Zip**_____

Policy#_____**GroupID:**_____

******PLEASE BRING YOUR INSURANCE CARD AND PHOTO ID ******

SLEEP QUESTIONNAIRE

Patient's Name:_____

Age: ____ **Height:** _____ **Weight:** _____

1. Please circle any of the sleep problems that relate to you. Number the three problems that are the worst.

Sleep Apnea	Daytime Fatigue
Loud Snoring	Poor Sleep Quality
Insomnia (falling asleep)	Not Enough Sleep
Insomnia (staying asleep)	Too Much Sleep
Narcolepsy	Nightmares
Restless Legs	Sleep Walking
Sleep Terrors	Leg Jerks
Sleep-Wake Schedule Problems	
Other_____	

2. How long have you had this/these problem(s)?

_____

_____

3. Do you now or have you ever had any of the following conditions? If yes please describe.

High Blood Pressure	YES	NO
Sinus Problems	YES	NO
Allergies	YES	NO
Heart Problems	YES	NO
Lung Problems	YES	NO
Tonsillectomy	YES	NO
Nasal Fracture	YES	NO
Nasal Surgery	YES	NO
Diabetes	YES	NO

4. Please list any other medical problems. How Long?

_____

_____

_____

_____

.

5. Please list all of your medications.

_____
_____
_____
_____

6. Please list any previous surgeries.

_____
_____
_____
_____
_____

7. Sleep Enviroment

Do you read in bed?	YES	NO
Do you watch TV in bed?	YES	NO
Do you share the bed with anyone?	YES	NO
Does your partner have a sleep disorder?	YES	NO
Do you have pets in the bedroom?	YES	NO

What is the temperature in your room? _____

8. Social History

Have you ever smoked?	YES	NO
If yes, average packs per day? _____		
Have you quit smoking?	YES	NO
If yes, how long ago? _____		
Do you drink alcohol?	YES	NO
If yes, how many drinks per day? _____		
Do you drink caffeinated beverages?	YES	NO
If yes, how beverages per day?_____		

9. What is your present occupation? _____

10. What are your work hours? _____

11. Family History

Marital Status

Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Number of of Children:_____ Ages : _____ Health: _____

Mother: Living? YES NO Age: _____ Health: _____
Father: Living? YES NO Age: _____ Health: _____
Brothers: Living? YES NO Age: _____ Health: _____
Sisters: Living? YES NO Age: _____ Health: _____

_____
_____
_____

12. Please answer the following questions using a scale from 0 to 4.
0= Not At All 2 = Sometimes 4= All the Time

Are you sleepy during the day?	0 1 2 3 4
Do you feel fatigued?	0 1 2 3 4
Do you have a problem falling asleep?	0 1 2 3 4
Do you snore?	0 1 2 3 4
Do you hold your breath or stop breathing while you sleep?	0 1 2 3 4
Do you have gas, indigestión, or heartburn?	0 1 2 3 4
Do you have night sweats?	0 1 2 3 4
Do you awake with headaches?	0 1 2 3 4
Do you have trouble breathing?	0 1 2 3 4
Do you have trouble breathing through your nose?	0 1 2 3 4
How many times do you wake to urinate?	0 1 2 3 4
Do you have difficulty breathing while lying flat on your back?	0 1 2 3 4

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Do you feel short of breath?	0 1 2 3 4
Do you ever choke on your food?	0 1 2 3 4
Have you ever wakened and felt paralyzed or unable to move?	0 1 2 3 4
While trying to fall asleep, do you ever have vivid dreams or hallucinations?	0 1 2 3 4
Do you have frequent, uncontrollable bouts of sleep, sleep attacks. or an irresistible urge to sleep?	0 1 2 3 4
Do you have muscle weakness when laughing?	0 1 2 3 4
Do you awaken gasping for air?	0 1 2 3 4
Do your legs kick or twitch at night?	0 1 2 3 4
Do your legs feel restless at night?	0 1 2 3 4
Do you have problems concentrating?	0 1 2 3 4
Do you have problems with impotence or lack of sexual interest?	0 1 2 3 4
Are you irritable?	0 1 2 3 4
Do you feel depressed?	0 1 2 3 4
Do you feel anxious?	0 1 2 3 4
Do you grind your teeth at night?	0 1 2 3 4
Have you ever caused a motor vehicle accident because you were tired?	0 1 2 3 4

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13. Sleep History

What is your usual bedtime on weekdays/workdays? _____

What is the usual length of time to fall asleep? _____

What is your usual wake up time? _____

What is the average of number of times you wake in a night? _____

Do you feel refreshed in the morning? YES _____ No _____

Do you nap during the day? YES_____No_____

If yes, how many naps, _____ and what is the duration of the naps? _____

Are the naps refreshing? YES _____ No _____

What is your usual bedtime on weekends/days off? _____

What is your usual wake up time on weekends/days off? _____

What is the usual sleep time per 24 hours during weekends/days off? _____

How many hours of sleep do you need to feel rested? _____

Please list any medication allergies.

_____

_____

_____

_____

SLEEPINESS SCALE

0 Would Never Doze
1 Slight Chance of Dozing
2 Moderate Chance of Dozing
3 High Chance of Dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place (theater, meeting, or classroom).	0 1 2 3
As a passenger in a car for an hour without a break.	0 1 2 3
Lying down for a rest in the afternoon when circumstances permit.	0 1 2 3
Sitting and talking with someone.	0 1 2 3
Sitting quietly after lunch without alcohol.	0 1 2 3
In a car stopped for a few minutes in traffic .	0 1 2 3

Financial Responsibility

Payment is due at time of service. We accept cash, check, Visa, MasterCard and American Express. We accept and bill insurance and will verify benefits prior to your visit.

You are responsible for any services not covered by your insurance plan and any out-of-pocket, including, but not limited to co-pays, deductibles, co-insurance, etc. When benefits are verified, Nevada Sleep Diagnostics provides you with an **ESTIMATE** only based on current information received from the insurance company. The actual balance may be different than originally quoted and you will be billed for the difference. Even if you have more than one insurance you may be responsible for a balance.

As a patient, it is in your best interest to understand your insurance plan benefits and your responsibility for deductibles, co-insurance, or copayment amounts. If your insurance does not cover a service, you may be liable for the entire amount. To find out more about your financial obligation, please call the customer service number of your insurance company.

Please sign and date below confirming that you have read and understood the content of this form in its entirety.

Signature: _____Date_____

Sincerely,
Nevada Sleep Diagnostics