7123 Commons Circle Cheyenne, WY 82009

Phone *307.638.4733* ***Fax*** *307.637.9108*

Thank you for scheduling with The Wyoming Sleep Disorders Center.

Enclosed are 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 do not hesitate to call our office.

In order to keep wait time to a minimum, we ask that you *arrive no more than 15 minutes early to your appointment.*

Please bring a photo ID, insurance card(s), and any specialty copayments required by your insurance.

Due to high volume of patients being seen at 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 your appointment, we would appreciate at least 12 hours' notice to help us accommodate other patients, we thank you for your 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 $35.00 to $75.00 fee for all No-Show appointments.

As an office policy, if you elect to terminate your sleep study earlier than the prescribed treatment requirements, we will not bill your insurance and you will be responsible for the fees associated with the terminated study.

If you no show a sleep study appointment or elect to terminate the study early you will need to go back to your referring provider prior to our office considering you again for the test.

We also reserve the rights to permanently decline your referral if you previously no showed, as no shows drive up the cost of care for everyone.

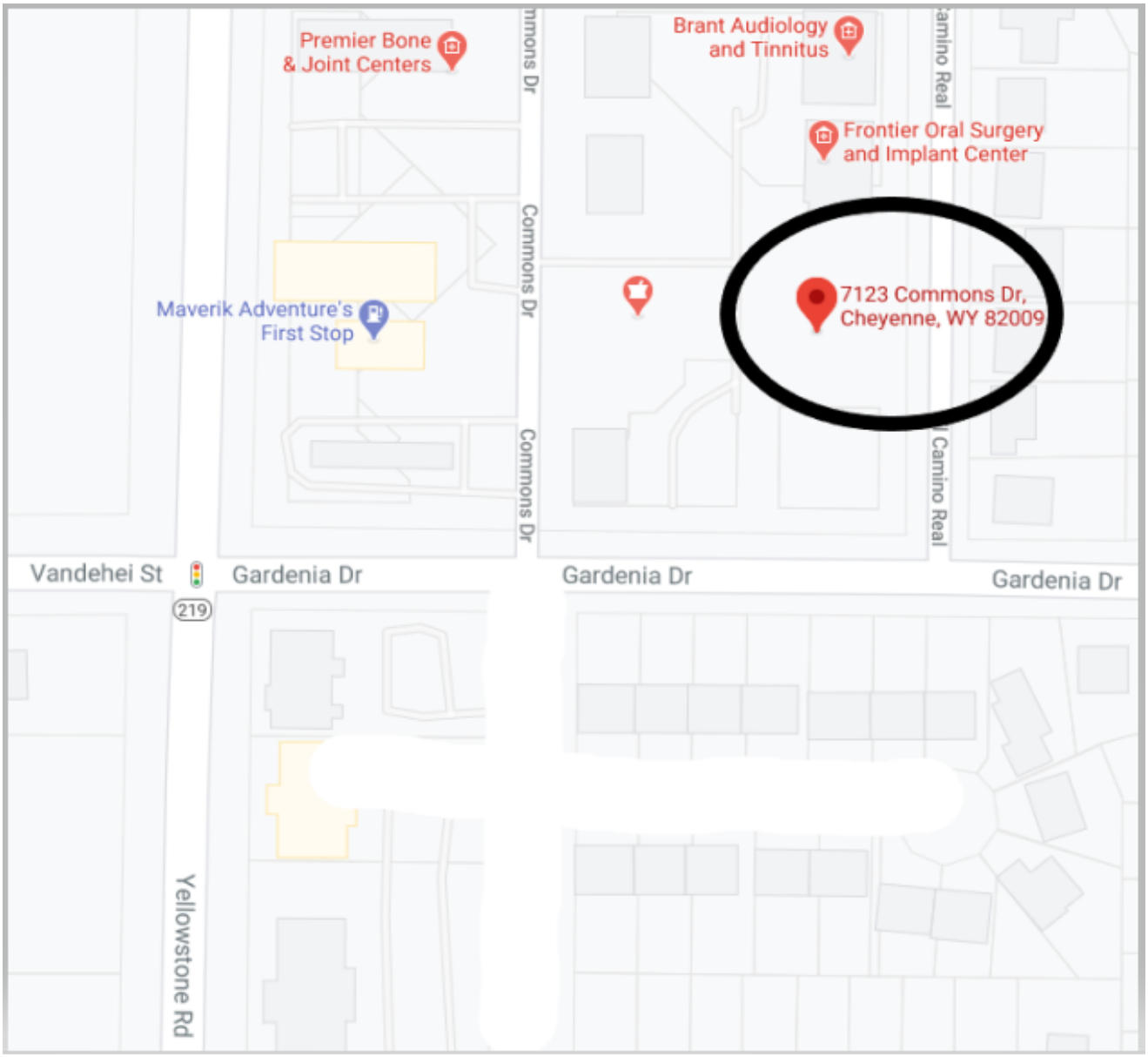
Again, thank you for choosing The Wyoming Sleep Disorders Center.

We look forward to serving you.

Important Sleep Study Information:

1. Check in time is 8:30 PM. Please try to avoid being here any earlier than 8:15 PM, unless prior arrangements are made. If you arrive prior to 8 pm you may be required to wait until staff arrives.
2. Your technologist will wake you up between 5 AM and 6 AM the following morning.
3. No excessive lotion, hair spray, hair conditioner, or makeup etc.
4. 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.
5. Please bring clothing to sleep in. The sleep center does not provide these.
6. Please bring a water bottle, pillow, and favorite blanket if needed.
7. 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.
8. There is a TV in your private room, but if you wish to read, please bring your own reading material or any other routine nighttime material
9. No caffeine after 8 AM on the day of your sleep study
10. If you have a CPAP machine now, you may bring your mask if you wish, although we will be fitting you for one at your sleep study.
11. All minors must be accompanied by a parent or guardian
12. We are a smoke free facility
13. Given the current pandemic we require a face mask/covering inside our facility

LOCATION MAP



Patients Personal Information

_____

Last Name First Name Middle Initial

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

Email _____ Sex () Male () Female

Cell Phone _____ Work Phone _____

Home/Mailing Address

_____City _____State_____ ZIP_____

Employer Name and Address

_____City _____State_____ ZIP_____

Responsible Party Information: Self (Same as above) () Spouse () Child () Other _____

_____

Last Name First Name Middle Initial

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

Email _____

Cell Phone _____ Work Phone _____

Home/Mailing Address

_____City _____State_____ ZIP_____

Primary Insurance

Insurance Name _____Policy # _____

Billing or Claim Address

_____City _____State_____ ZIP_____

Subscriber _____ Date of Birth _____

Relationship _____

Secondary Insurance

Insurance Name _____Policy # _____

Billing or Claim Address

_____City _____State_____ ZIP_____

Subscriber _____ Date of Birth _____

Relationship _____

Epworth Sleepiness Scale

Name: _____ Date: _____

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= 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 theatre 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:

Patient Name _____ Date of Birth _____

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

Provider that sent you _____

Primary Care Provider _____

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

Current Height: _____ ***Current Weight***:_____

() 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

Pertinent Family Medical History

Father: _____ Mother: _____ Siblings: _____

Other: _____

List other past surgeries/past hospitalizations/injuries with dates AND Medications – *Please use an additional sheet if required.*

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	Daly/Weekends/Rarely	_____# of glasses
			() Liquor	Daily/Weekends/Rarely	_____# of shots

Please check all 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 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
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/	( ) environmental allergies, ( ) food allergies, ( ) immunocompromised state
Neurological:	( ) dizziness, ( ) tremors, ( ) seizures, syncope, ( ) facial asymmetry, ( ) numbness,
Hematological:	( ) adenopathy, ( ) bruise/bleed easily

Psychiatric/ ( ) 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, test results, diagnosis, 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 reviews notice to the address I have 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 in writing except to the extent that the organization has already taken 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, noncovered treatment or testing that I have agreed to, etc., and that if I am experiencing difficulty meeting my obligations it is my responsibility to notify the Wyoming Sleep Disorders Center's billing department to make reasonable payment arrangements.

Patient Printed Name: _____

Patient/Guardian Signature: _____ Date: _____

Relationship if Guardian: _____

CONSENT FOR PATIENT PHOTOGRAPHY

Name: _____ Date of Birth _____

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, a second witness is required

_____

Second Witness