SLEEP LAB
OF LAS CRUCES

Welcome to Sleep Lab Of Las Cruces

This packet contains information needed for your evaluation of Sleep Matters. Please bring these forms **completed** as well as a list of current medications with doses to your visit. Bring records of prior sleep studies, sleep evaluations, prior treatments, or material from your physician. Bring your questions. Bed partners are welcome to attend and offer their experiences with your sleep.

If you have a CPAP, BiPAP, or another small device used with sleep please bring it along with the power cord.

At the beginning our office will collect a copy of current insurances, copy of a picture Identification, and any co-pay/deductibles. If pertinent you should bring the referral form(s) for this visit from your Family doctor. If you access medical care without needed referrals or insurance clearance you will pay for all costs incurred.

It is the patient's responsibility to check for covered services including overnight sleep studies and have approvals for care prior to attending any appointment. **The patient is responsible for all expenses and/or costs incurred.** Know your pay sources

As a **specialty** office we focus on sleep health issues and sleep treatments. Your family doctor is important and must coordinate all of your ongoing health/medical needs and care including hospitalizations. We plan to send summaries of our interaction to your family doctor and other specialty physicians. We do not attend at any hospital but will confer with your doctor(s). **After hours and weekend care is thru your family doctor.** Ask the staff about refills to meds given here.

Patient's signature_____ **DATE:**_____

I have read material presented

2015

2437 S. Telshor Blvd. Las Cruces NM 88011
Phone (575)522-2777 Fax (575)522-4532
REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Divorced / Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no. : Mobile Phone ( ) ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone . : Mobile Phone ( ) ( )

Preferred Pharmacy?

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	Policy#	Group#

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. I also authorize Paul Feil M.D. Gregory Charlton M.D. Sleep Lab of Las Cruces or insurance company to release any information required to process my claims.

Signature –patient or guardian _____ Date _____

SLEEP LAB OF LAS CRUCES

CONSENT
PURPOSES OF TREATMENT, PAYMENT, HEALTHCARE OPERATIONS

I consent to the use of disclosure of my Protected Health Information (**PHI)** by Sleep Lab Of Las Cruces (hearin after known as Sleep Lab) for the purpose of the following:
1) Diagnosing and providing treatment to Me
2) Obtaining Payment for my health care bills
3) Conducting the health care operations of the Sleep Lab
I understand that diagnosis or treatment of me by Sleep Lab may be conditioned upon my request as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment/diagnosis, payment, or healthcare operations of Sleep Lab. This request to restrict must be submitted to Sleep Lab in writing. Sleep lab is not required to agree to the restriction that I may request.

I have the right to revoke this consent in writing at any time except to the extent that Sleep Lab has taken action in reliance on this consent.

DEFINITION OF PROTECTED HEALTH INFORMATION(**PHI)-** health and demographic information collected from me as well as that created or received by physician/office staff from sources not limited to other health providers, employers, health plans, health clearing houses. This PHI relates to my past, present or future health(mental and physical) and identifies me or likely identifies me.

HIPAA regulations- I have received and reviewed the Notice of Privacy Practices. This document describes the types of uses and disclosures of my PHI that will occur during my treatment/evaluation, payment of bills and in the performance of health care operations by Sleep Lab. My signature below attests to my understanding and agreement. Sleep Lab may change aspects of the privacy practices(within federal mandates) after notification.

PATIENT NAME_____ Date of Birth_____SS #_____
Address_____phone#_____
City,State,Zip_____
SIGNATURE_____DATE_____- 2015

Sleep Lab of Las Cruces
Sleep History Packet

Please answer these questions keeping in mind the following:

a) Answer each question in relation to the last **6 months**, unless otherwise specified.
b) A "**weekday"** should be thought of as any day that you routinely work:

if you do not work, a weekday is Monday through Friday.

c) If you are engaged in **shift work** or have any type of unusual sleep/wake schedule, "day" and "night" should be interpreted as your major wake and sleep periods respectively.

d) these answers may guide later physician questions

_____ _____

Name **Date**

My main sleep complaint involves (mark all that apply)

____ trouble sleeping at night **____ being sleepy all day**
____ unwanted problems or behaviors during sleep **____other**

Have you had a sleep study before?_____ If yes when?_____ Where?_____

Person Referring_____ Family Doctor(S)_____

Please describe your sleep problem(s):_____
_____
_____
_____

My sleep/wake problem began (date and some details):_____
_____
_____
_____

What have you done to help/treat your problem?:_____
_____
_____
_____

2015

Please answer ALL 23 questions below to the best of your ability by circling the number (0-3) that most closely describes the degree of the frequency that you are bothered by a particular complaint or problem during the last month. For questions which ask about a bed partner, do not circle any number if you do not have a bed partner.

0 = Never or None
1 = Seldom or a Small Amount
2 = Often or a Moderate Amount

3 = Almost Always or a Large Amount

1) How often do you fall asleep during the day when you are not busy or not moving around?(on computer, driving, watching TV)	0	1	2	3
2) How often do you awaken feeling unrested even after adequate hours of sleep?	0	1	2	3
3) How often do you suffer from unexplained fatigue or tiredness during the day?	0	1	2	3
4) How often do you awaken feeling really sleepy or groggy?	0	1	2	3
5) How much trouble do you have with snoring?	0	1	2	3
6) How often has a bed partner noted you stop breathing during sleep?	0	1	2	3
7) How often is your sleep disturbed by other problems? Describe:_____	0	1	2	3
8) Do you suffer from headaches on **awakening?**	0	1	2	3
9) How often do you awaken in sleep with heartburn or stomach acid in the mouth?	0	1	2	3
10) Do you have a dry mouth upon awakening?	0	1	2	3
11) How great of a problem do you have getting to sleep?	0	1	2	3
12) How often do you wake up and have trouble falling back to sleep?	0	1	2	3
13) How much do you toss and turn during your sleep?	0	1	2	3
14) How often has a bed partner noted that your legs twitch or kick in your sleep?	0	1	2	3

CIRCLE
0=Never or None
1= Seldom or a Small Amount
2= Often or Moderate Amount
3= Almost Always or a Large Amount

15) How often are you troubled by restless or "creepy" legs (ormigas) in the evening or night?	0	1	2	3

16) How often do you feel completely paralyzed or "stuck" when just falling asleep or waking up?	0	1	2	3
17) How often do you hallucinate people, voices, or sounds in the room when just falling asleep or when just awakening?	0	1	2	3
18) How often during the day do you have episodes of sudden muscular weakness when laughing, angry, or in other emotional situations?	0	1	2	3
19) How often do you have unusual behaviors in your sleep? Circle the type of unusual behaviors you have experienced: walking, screaming out, nightmares, violence, eating, confusion, other_____	0	1	2	3
20) How much does your current sleep problem affect your family life or work?	0	1	2	3
21) Is your sleep quality poor?	0	1	2	3
22) How much does your current sleep problem affect your sense of well being?	0	1	2	3
23) Do you use alcohol, sleep meds or marijuana **before** bed?	0	1	2	3

Try to be specific with the following questions. Please rate your answer based on your average night.

Do you go to bed at approximately the same time every night?_____
What time do you usually go to bed?_____AM/PM

Do you arise from bed at approximately the same time every day?_____
What time do you usually arise for the day?_____AM/PM

Are you a shift worker?_____

List the amounts of the following beverages you consume almost daily.

After 3 pm

Cups of coffee _____
Tea (glasses or cups) _____
Carbonated drinks (can/bottle)_____
Beer, wine, liquor (can/bottle) _____

Energy Drinks (can/bottle)_____
Recreational drugs (list):_____
_____

List all medications (prescribed by a doctor, over-the-counter, such as Unisom, Sominex, Vivarin, No Doze,Herbal perparations, dietary supplements) that you have taken for your Sleep problems?

Medication for sleep	Dose	times daily	helpful?	Still using?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do anyone of your blood relatives have a sleep disorder?_____

Allergic to any medications?_____ Specify:_____

Has your weight changed recently? Yes_____ No_____ gain or loss?_____

MEDICAL HISTORY— circle Yes or No for each question and circle the condition(ie stroke)

A) Heart, Stroke, Circulatory, Vascular disease, High Blood Pressure, cholesterol disorder YES NO

B) Cancer, Tumors, Cysts, Leukemia, Lupus, Hepatitis A- B- C YES NO

C) Multiple Sclerosis, Cerebral palsy, Polio, Muscle disorders, arthritis(type_____) YES NO

D) Allergies, Asthma, Emphysema, COPD, lung disorders, occupational lung disorder YES NO

E) Disorder of EYE-EAR-NOSE-THROAT-TONSIL-ADENOIDS(type_____) YES NO

F) Diabetes, thyroid disorder, pancreatitis, endocrine disorder YES NO

G) AIDS, HIV, Immune systems disorder, blood disorders, too thick blood YES NO

H) Liver disorder, Cirrhosis, Irritable bowel, Colitis, gall bladder , GERD/reflux, Crohn's YES NO

I) Kidney disease, stones, dialysis, prostate disease, ovary illness, menstrual disorder YES NO

J) Migraines, AM headaches, Severe Head Trauma, Seizures, depression, chronic pain YES NO

K) Surgery to neck or throat or mouth…….TYPE done and when_____ YES NO

L) Is there any condition not previously listed that has been a medical concern? YES NO

M) Have you used cigarettes or tobacco products or e cigarettes in the last 24 months? YES NO

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate number for each situation you may have experienced.

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 television	0	1	2	3
Sitting inactive in public (i.e., meeting or theater)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting or talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car while stopped for a few moments in traffic	0	1	2	3

Bed Partner Questionnaire

Name of Patient:_____

Name of person filling out this form:_____

How many times a week do you observe partner's sleep behavior?_____

Check any of the following behaviors that you have observed this person doing <u>while sleeping:</u>

____light snoring	_____loud snoring	_____occasional loud snorting
____choking	_____pauses in breathing	_____twitching or kicking legs
____grinding teeth	_____sleepwalking	_____twitching or jerking arms
____bed-wetting	_____biting tongue	_____getting out of bed
____crying out	_____awakening with pain	____sitting up in bed
____becoming very rigid and/or shaking		_____head-rocking or banging
____apparently sleeping even if she/he behaves otherwise		
____other:_____		

Please describe the sleep behavior checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____
_____
_____
_____
_____
_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? _____Yes _____No

If yes, please explain:_

_____
_____
_____
_____
_____
_____

Thank you for completing this questionnaire. Please bring it with you to sleep lab.