Patient Name:_____
(Please Print)

Oxy # _____

OXIMETRY STUDY INFORMED CONSENT

Please read the following information to familiarize yourself with the type of test you will be having as a patient in the Utah Sleep & Pulmonary Specialists Clinic.

The Oximetry test consists of attaching a sensor on the finger to measure oxygen saturation throughout the night. This includes taping the sensor to the finger, which may cause a slight skin irritation in some people. There will be a cable connecting the sensor to the monitoring equipment (the oximeter).

To enable the test to be as accurate as possible, you need to be familiar with the operation of the equipment, so ask questions until you are comfortable. You will be instructed how to turn the equipment ON/OFF prior to taking the machine home. When you are ready for bed and the sensor is on your finger turn the oximeter ON; in the morning turn the oximeter OFF and remove the sensor. Every oximeter will have a fresh battery when you take it home, so there will be no need for you to change it. You should continue to take any medication prescribed by your doctor unless told otherwise.

You are responsible for the equipment once it leaves Utah Sleep and Pulmonary Specialists. Please take good care of the equipment; it is sensitive to "bumps" and extreme temperatures, such as leaving it in the car for sustained periods. By accepting this equipment, you also agree that it will be returned in good working condition. **If equipment is visibly damaged or not returned you will be responsible to pay $500.00 for replacement.**

Please return the equipment to Utah Sleep and Pulmonary Specialists on the next business morning (following your study) unless other arrangements are made. Your prompt return of the Oximeter will enable us to furnish your physician with the results quickly.

I have read and understand the above.

_____ _____
Signature of Patient Date

_____ _____
Signature/Relationship to Patient Date

Reason for patient's inability to sign: _____

_____ _____
Signature of Witness Date

If my insurance denies payment for this test ("non-covered benefit", "not medically necessary")
I agree to pay $20.

_____ _____
Signature Date

Oximetry Study Instructions

Utah Sleep & Pulmonary Specialists
9103 South 1300 West #103
West Jordan, Utah 84088
(801) 432-8690

AT BEDTIME:

1. Prepare for bed, wash hands and attach sensor to finger.
    a. Preferably on index finger of non-dominant hand
    b. Secure wire to back of hand with a piece of tape

2. Complete the "bedtime" portion of the Bedtime/Morning Questionnaire.

3. Turn on the oximeter by pressing the power button, making sure numbers appear in the display window (this takes approximately 30-seconds). If the numbers fail to appear, check the connections:
    a. Where the sensor attaches to the cable and where the cable attaches to the oximeter.
    b. It may be necessary to gently push the connections together to complete the connection.

DURING THE NIGHT:

If you need to get out of bed during the study, please DO NOT TURN OFF. Remove it if you need to, reapply when you return to bed. Check the display window of the oximeter to insure that it is still functioning correctly. If you notice the red light inside the finger sensor is off, check the cable connection and/or press the power button once to turn off and press again to turn back on.

IN THE MORNING:

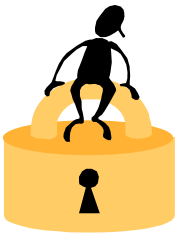
1. Turn off the oximeter by pressing the power button. Remove the sensor from your finger and place in carrying case.

2. Complete the "morning" portion of the Bedtime/Morning Questionnaire.

3. Complete the additional 2-page Sleep Questionnaire.

4. Return the oximeter to Utah Sleep and Pulmonary Specialists as close to 9:00 a.m. as possible. Your prompt return of the Oximeter will enable us to provide your physician with the results quickly.

PATIENT NAME: _____
(Please print name)



HIPAA – Notice of Privacy Practices Acknowledgement

I acknowledge that I have had an opportunity to read, take a copy and make changes in writing of the Provider's "Notice of Privacy Practices" (HIPAA Notice). This is available in the office or online (www.utsleep.com) and explains when, where, and why my confidential health information may be used or shared. Dr. Gregory Dupont, Dr. Kathleen Pfeffer and their staff may use and share my confidential health information with others only as needed for treatment, payment of my bill or for healthcare operations (such as tests ordering or communicating with my doctor(s), unless otherwise specified.

_____ _____
Signature of patient/person authorized to consent **Date**

Please share my medical information with the following people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of patient/person authorized to consent **Date**

A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:
  _____
- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):
  _____

Signature of Employee Completing Form: _____

Date Signed: _____

NAME:_____
Last First

TODAY'S DATE:____/____/____ **BIRTHDATE:**____/____/____ _____
Age

SEX: M F _____ _____ _____
Height Weight Neck Size

REFERRING DOCTOR:_____
Last First

Sleep Questionnaire

Utah Sleep & Pulmonary Specialists

BEDTIME QUESTIONNAIRE

(Complete ***before*** test begins)

1. Has today been unusual in any respect? Y N If yes, why?_____
2. How much sleep did you have last night?_____hours. Was this adequate? Y N
3. Did you nap today? Y N If yes, at what time?_____How long did you sleep?_____
4. On the table below, list all medications you usually take. Include vitamins, aspirin, etc.

NAME OF USUAL MEDICATION *(PLEASE PRINT THIS INFORMATION CAREFULLY, TAKING NAMES AND SPELLING DIRECTLY FROM THE CONTAINERS.)*	**USUAL AMOUNT**	**TONIGHT BEFORE TEST (circle one)**		**DURING THE TEST? (circle one)**	
		Y	**N**	**Y**	**N**
		Y	**N**	**Y**	**N**
		Y	**N**	**Y**	**N**
		Y	**N**	**Y**	**N**
		Y	**N**	**Y**	**N**
		Y	**N**	**Y**	**N**
		Y	**N**	**Y**	**N**
		Y	**N**	**Y**	**N**
		Y	**N**	**Y**	**N**

5. Did you drink any alcohol or caffeinated drinks this evening? Y N If yes, what type and how much?_____
6. Any drug allergies? ____ No. If yes, please list:
7. Please list any physical complaints you have now, or additional information:

MORNING QUESTIONNAIRE

(Complete ***after*** the test ends)

1. Did you sleep with oxygen? Y N If yes, how much?_____liters/min.
2. Did you sleep with nasal CPAP? Y N If yes, how much?_____cmH2O.
3. How long did it take you to fall asleep last night after the lights were turned out?_____hours and _____minutes.
4. How does this compare with the time it usually takes you to fall asleep?
   ☐much longer ☐longer ☐same ☐shorter ☐much shorter
5. How long did you feel you slept last night?_____hours and _____minutes.
6. How does this compare with the length of time you usually sleep?
   ☐much longer ☐longer ☐same ☐shorter ☐much shorter
7. How many times do you remember waking up last night?_____times.
8. How do you feel right now compared with your usual feeling in the morning?_____
9. Do you have any physical complaints this morning? Y N If yes, what?_____
10. What awakened you this morning? ☐noise ☐technician ☐discomfort ☐spontaneous ☐other_____
11. In general how would you say your sleep last night compared with your usual sleep?_____
12. Shade in the hours you think that you were asleep while being monitored and, in this way, indicate the approximate time and duration any major wake periods during the night. (Lights OUT time:_____; Lights ON time:_____).

6PM----7----8----9----10-----11-----MIDNIGHT-----1-----2-----3-----4-----5-----6-----7-----8---9---10---11AM

Utah Sleep & Pulmonary Specialists
(801) 432-8690

NAME: _____
Last **First**

TODAY'S DATE: ____/____/____ **BIRTHDATE:**____/____/____ _____
Age

SEX: **M** **F** _____ _____
Height Weight

REFERRING DOCTOR: _____

Sleep Questionnaire

Please read the following questions and check the box to the left that corresponds to the response which best answers the question for you ***during the past year.*** Answer all questions even if they seem similar.

Rarely/Never	Sometimes	Often		
____	____	____	01.	Do you have difficulty falling asleep?
____	____	____	02.	Do you wake up earlier in the morning than you would like to?
____	____	____	03.	Have you been told that you snore?
____	____	____	04.	Have you been told that you stop breathing while asleep?
____	____	____	05.	Do you have morning headaches?
____	____	____	06.	Do you suddenly wake up gasping for breath during the night?
____	____	____	07.	Are you overweight?
____	____	____	08.	Are you losing your sex drive?
____	____	____	09.	Do you feel sleepy during the day, even if you slept enough?
____	____	____	10.	Do you have trouble concentrating at school or work?
____	____	____	11.	When you are angry or surprised do you feel like you're going limp?
____	____	____	12.	Have you fallen asleep while driving?
____	____	____	13.	Do you feel like you're hallucinating when you fall asleep?
____	____	____	14.	Do you have trouble at work because of sleepiness?
____	____	____	15.	Do you fall asleep during the day?
____	____	____	16.	Do you feel unable to move when you wake up or fall asleep?
____	____	____	17.	Have you (or others) noticed that parts of your body jerk?
____	____	____	18.	Have you been told that you kick at night?
____	____	____	19.	Do you experience aching or crawling sensations in your legs?
____	____	____	20.	Do you have trouble keeping your legs still when lying/sitting?
____	____	____	21.	Have you experienced abnormal behaviors while asleep?
____	____	____	22.	Do you have discomfort or pain disturbing your sleep?
____	____	____	23.	Do you drink alcohol in the evening?
____	____	____	24.	Do you drink caffeine drinks in the evening?
____	____	____	25.	Do you use medication to help you sleep?
____	____	____	26.	Do you use medication to help you stay awake?
____	____	____	27.	Have you been told that your sleep is abnormal?
____	____	____	28.	Do you sleep walk or talk in your sleep?
____	____	____	29.	Do you have swelling in your feet/hands?

1. What is your normal bed time? From _____ until _____ (Weekend: From _____ until _____)
2. During that time, how many hours of sleep do you usually get? _____ (Weekend: Hours of sleep _____)
3. Why do you think you are being tested?
4. Describe your problem:
   a. How long have you had it?
   b. What have you done about it?
   c. How has it affected your quality of life?

5. Do you use a Nasal CPAP at home now? Y N What level?_____
How do you feel since using CPAP? ☐worse ☐about the same ☐better ☐much better ☐other (explain):

Have you had the following study before:	When:	Results:
Polysomnography (full sleep study with many wires)		
Nasal CPAP		

Do you use supplemental oxygen at:	Y	N	What level (liters)?
Nighttime			
Daytime			

Have you had any of the following? Please explain briefly. When did it happen? Is it a problem now?

Have you ever had:	Y	N	When:	Brief Explanation:	Is this still a problem? Y	N
Low thyroid problems						
Brain infection/tumor/trauma						
Tonsillectomy						
Epilepsy						
Diabetes						
Hypertension						
Stroke						
Lung disease/type						
Heart disease/type						
Recent weight gain						
Gastric reflux						
Polycythemia (too many red blood cells)						

Please list all other medical problems not already described:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 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 affect you. Using the following key, circle the number which corresponds to the ***most appropriate number*** for each situation.

KEY
0 = ***NEVER*** doze
1 = ***SLIGHT*** chance of dozing
2 = ***MODERATE*** chance of dozing
3 = ***HIGH*** chance of dozing

SITUATION	CHANCE OF DOZING (circle the number corresponding to the key above)			
Sitting and reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting, inactive in a public place(e.g., a theater or a meeting)	**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 and talking with someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in the traffic	**0**	**1**	**2**	**3**

_____