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

_____is scheduled for a _____
On _____ at _____.

Your sleep study is scheduled for the date and time indicated above. Please arrive at the scheduled time. The technician arrives only 15 minutes before you. If you have any questions, please call (801) 432-8690. You must notify Utah Sleep and Pulmonary Specialists at least 24 hours in advance should you need to change your appointment or you will be charged $50. Failure to show up for your test will also result in a $50 charge. PLEASE BRING YOUR INSURANCE CARD.

Patient signature (responsible party): _____

Date: _____

Additional Instructions

- Please come freshly showered with clean, dry hair. (Men should come freshly shaven; beards and mustaches trimmed). Avoid using creams or lotions on your body. This will allow the equipment placed on you to conduct a clearer signal and will expedite the analysis process of the study.
- Fill out the enclosed questionnaires and Patient Information form. Please bring ALL of the paperwork, along with insurance verification if we have not already received this from you to your appointment. Some of the paperwork may seem redundant; however it is important to bring it with you filled out to your sleep study.
- You are encouraged to bring any items that will help you feel more comfortable such as: pajamas (loose fitting 2-piece under and outer wear, robe and slippers are recommended) favorite pillow, book to read. However, please leave all valuables at home. You should bring any prescribed medications with you, or take them before arriving at the clinic
- Alert the technician if a specific wake-up time is needed. Otherwise you may be awakened at 5:00 AM or earlier

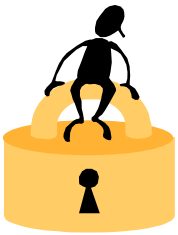
Utah Sleep & Pulmonary Specialists

Sleep Studies - What to Expect

- Please come freshly showered with clean, dry hair. Avoid using creams or lotions.
- Upon arrival at the sleep center you will be greeted by a sleep technician. The technician will verify your information, collect your paperwork and show you to your room.
- You will be given some time to change into your sleeping attire and make yourself comfortable. When you are ready, call the technician and they will begin the process of preparing you for the study.
- Please let us know if you have ANY additional needs or limitations (physical, social, etc.)
- An overnight sleep study for sleep apnea or other sleep disorder consists of attaching sensors to the body to measure chest and abdomen respiration, heart activity body movement, sleep stage, muscle activity, oxygen saturation, airflow and more. This includes cleaning the skin and taping sensors to the face, scalp, chin, chest and legs. The test is essentially painless but some discomfort may be experienced while the electrodes are being applied or removed.
- After the sensors are attached you may need to perform some breathing exercises. The technician will also have you move different parts of your body at various times to check the monitoring system.
- Although the technician may not administer medication of any kind, you SHOULD CONTINUE to take any medication prescribed by your doctor unless told otherwise.
- While sleeping in one of our sleep rooms at the center, a technician will monitor you from a nearby room. If you need to use the restroom during the night, please notify the technician. Please contact the technician if you need assistance of any kind. Snacks, juice and coffee are available in the morning after your test.
- Alert the technician if a specific wake-up time is needed.
- In the morning the technician will awaken you and unhook you from the monitoring equipment. You will then be asked to complete some additional paperwork including a morning questionnaire and satisfaction survey.
- Results of the study will be sent to your referring physician. The technician cannot provide any diagnostic information, interpret your symptoms or evaluate the outcome of your study.

IF YOU HAVE QUESTIONS PLEASE CALL (801) 432-8690

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

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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**

_____

Patient Name:_____

(Please Print)

POLYSOMNOGRAPHY/EGG 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 Polysomnography test for sleep apnea or other sleep disorders consists of attaching sensors to the body to measure chest and abdomen respiration, heart activity, body movement, sleep stage, muscle activity, oxygen saturation, airflow and more. This includes cleaning the skin and taping sensors to the body which may cause a slight skin irritation in some people. Sensors will be taped to the face, scalp, chin, chest, and legs. The test is essentially painless but you will be asked to keep your eyes closed when the electrodes are being applied to or removed from your face. You will have cables on your body connecting the sensors to the monitoring equipment.

In addition you may perform some breathing exercises. These will include holding your breath while you are pushing your stomach in and out. This exercise may need to be repeated several times. The technician will also have you move different parts of your body at the beginning of the test.

The EEG sleep test (some patients do this part only) involves sensors applied to the scalp. This test is done to look for evidence of seizures while you sleep and may not involve any other monitoring.

Although the technician may not administer medication of any kind, you should continue to take any medication prescribed by your doctor unless told otherwise. The technician is trained to perform the specific test which has been ordered by your doctor and cannot provide any diagnostic information, interpret your symptoms or evaluate the outcome of your study. This is only one test providing specific information which will be added to your medical file. You will be receiving a bill for the sleep/EEG test, and you will receive a separate bill from the physician for the medical interpretation of the test.

A technician will monitor you from a nearby room. Please contact the technician if you need assistance of any kind. Other services, such as nursing assistance, are not provided. Snacks, juice and coffee are available in the morning after your test.

I have read and understand this and my questions have been answered to my satisfactorily.

_____ _____

Signature of Patient Date

_____ _____

Signature/Relationship to Patient Date

Reason for patient's inability to sign:_____

_____ _____

Signature of Witness Date

Patient Name:_____

(Please Print)

CPAP or BIPAP TITRATION 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 Nasal Continuous Positive Airway Pressure (CPAP) test begins similarly to a test for other sleep disorders and consists of attaching sensors to the body to measure chest and abdomen respiration, heart activity, body movement, sleep stage, muscle activity, oxygen saturation, airflow and more. This includes cleaning the skin and taping sensors to the body which may cause a slight skin irritation in some people. Sensors will be taped to the face, scalp, chin, chest, and legs. The test is essentially painless. You will be asked to keep your eyes closed when the electrodes are being applied to or removed from your face. You will have cables on your body connecting the sensors to the monitoring equipment.

In addition you will perform some breathing exercises. These will include holding your breath while you are pushing your stomach in and out. This exercise may need to be repeated several times. The technician will also have you move different parts of your body at the beginning of the test.

Prior to going to bed, or at sometime during the test, a CPAP mask will be attached to cover your nose. This mask is connected with a hose to a device providing gentle air pressure which will be adjusted according to your needs during the night to aid you in breathing with less effort while asleep. A technician will be monitoring you throughout the night from the next room and will adjust the airflow pressure to the best levels to reduce your symptoms. You may experience some discomfort such as dry or running nose, dry throat and eyes, ear pressure, skin irritation, chest pains (rare), gas pains (rare), or poor fitting mask. A poor fitting mask may feel uncomfortable or tight or may leak air around the eyes or upper lip. Please let the technician know of <u>any</u> <u>discomfort</u> that you are having.

Although the technician may not administer medication of any kind, you should continue to take any medication prescribed by your doctor unless told otherwise. The technician is trained to perform the specific test which has been ordered by your doctor and cannot provide any diagnostic information, interpret your symptoms or evaluate the outcome of your study. This is only one test providing specific information which will be added to your medical file. Your physician will receive and interpret this information. You will be receiving a bill for the sleep test, and you will receive a separate bill from the physician for the medical interpretation of the test.

Please contact the technician if you need assistance of any kind. Other services, such as nursing assistance, are not provided. Snacks, juice and coffee are available in the morning after your test.

I have read and understand this and my questions have been answered to my satisfactorily.

_____ _____

Signature of Patient Date

_____ _____

Signature/Relationship to Patient Date

Reason for patient's inability to sign:_____

_____ _____

Signature of Witness Date

Patient Satisfaction Survey

Utah Sleep & Pulmonary Specialists
(801) 432-8690

In order for the Sleep Disorders Clinic to more adequately meet your needs and continually improve our service to patients, would you please take a few minutes and provide us with some helpful information? **Please enclose and seal in the attached envelope.** Your comments will be viewed by a manager.

Study Date: _____/_____/_____

☐OXIMETRY (finger sensor only)
☐POLYSOMNOGRAPHY (full study)
☐CPAP (with mask)
☐BIPAP (with mask)
☐OTHER _____

1. Did you experience any difficulties in scheduling your sleep test?
   ☐Yes ☐No Comments:_____
2. Any problem with parking or getting into the building?
   ☐Yes ☐No Comments:_____
3. Was the technician there to greet you when you arrived?
   ☐Yes ☐No Technician's name, if you remember:_____
4. How long did you wait after your scheduled appointment time until the technician began preparing you for the test?
5. Did the technician adequately explain the procedure? ☐Yes ☐No
   Were your questions answered to your satisfaction? ☐Yes ☐No
6. Did the technician make you feel comfortable and at ease? ☐Yes ☐No
   Was any aspect of your visit especially uncomfortable? ☐Yes ☐No
   Comments:_____
7. Did the technician seem to be knowledgeable about the procedures he or she was performing? ☐Yes ☐No
8. Overall, how would you rate your visit to the Sleep Clinic?
   - ☐ Very Good or Excellent
   - ☐ Good
   - ☐ Average (Not good or bad)
   - ☐ Below Average
   - ☐ Poor
9. What improvements could be made to serve you better?
10. Other comments:

Thank you for your time and effort in completing this information.

Sincerely,

Dr. Dupont and Dr. Pfeffer
Utah Sleep & Pulmonary Specialists

UTAH SLEEP & PULMONARY SPECIALISTS
9103 SOUTH 1300 WEST
SUITE 103
WEST JORDAN, UT 84088

From I-15 take the 9000 south exit and head west until you reach the light at 1300 west and then turn left (south). It will be on your left (the east side of the street) with Jordan Valley Dental on the corner. We are in suite 103 which is in the middle of the office strip.