



Neuro Diagnostic Sleep Centers

Epworth Sleepiness Scale Assessment

Developed by Dr. Murray Johns of Melbourne, Australia

This questionnaire is meant to measure daytime sleepiness. (Source: Sleep 1991; 14(6): 540-545).

Think back over the past several weeks and try to evaluate your sleepiness doing the following situations. The Epworth Sleepiness Scale asks you to rate your degree of sleepiness in each situation. Try to rate yourself in these situations even if you haven't participated in these situations for a long time. Use the following numerical rating scale to rate each of the following situations as they pertain to you.

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

DURING THESE SITUATIONS

WHAT ARE YOUR CHANCES OF DOZING?

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 to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

To check your sleepiness score, total the points. Check your total score to see how sleepy you are.

THE EPWORTH SLEEPINESS SCALE KEY

- 1 - 6 Congratulations, you are getting enough sleep!
- 7 - 9 Your score is average.
- 10 and up Suggests you may suffer from excessive sleepiness and should seek medical attention.

Pt's Name: _____

Pt's signature: _____ Date: _____

Patient History Form

Last Name First Name Middle Date

Date of Birth Age Sex Are you Right or left handed?

What is the main reason you are seeing a neurologist? Describe onset. When did it start? What makes it worse or better, etc, etc...? _____

Medical History: List all medical conditions (e.g. diabetes, heart disease, high blood pressure, high cholesterol, arthritis, etc...) _____

LIST ALL SURGERIES AND DATES: _____

Any major accidents or injuries? _____

Any recent hospitalizations? (if yes, give details) _____

ANY ALLERGIES TO MEDICATIONS? Yes or No (if yes, list medication and reaction) _____

MEDICATIONS (List all medications with dosage and frequency you are currently taking? If needed, attach a separate page. _____

Have you had any of the following problems (check all that apply)? If yes, please explain.

Heart Disease	<input type="checkbox"/>	Neurologic (seizure, stroke, etc.)	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Abdominal (stomach/intestinal)	<input type="checkbox"/>	Psychological	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	Kidney or urinary problems	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Cancer (where and what treatment)	<input type="checkbox"/>	Ear, Nose, or Throat	<input type="checkbox"/>

Please explain all yes answers, and describe other conditions:

Review of Symptoms: Do you have any of the following conditions or complaints? (Check all that apply)

Neurologic	Headache		Musculoskeletal	Muscle pain		
	Fainting/blacking out			Joint pain (if yes, where?)		
	Seizures			Psychiatric	Pain in any body part (if yes, where?)	
	Dizziness		Depression			
	Difficulty in speech		Anxiety			
	Memory problems more than age related		Bipolar Disorder			
	Muscle weakness		Infectious		Sexually transmitted disease	
	Numbness or tingling				HIV/AIDS	
	Difficulty walking				Hepatitis	
	Difficulty using hands			Tuberculosis		
Tremors			Scabies			
Constitutional	Fever			Other (please list)		
	Weight gain or loss		For Women	Menstrual problems		
	Sleep problems			Are you pregnant?		
	Fatigue			Are you planning on having children within the next year?		
Eyes	Double vision			Do you take birth control pills?		
	Blurred vision		Have you had a hysterectomy?			
	Eye pain		Other (Please list)			
	Other					
Ears, Nose, and Throat	Difficulty swallowing					
	Hearing loss					
	Hearing aids					
	Ringing in ears					
Cardiac	Ear pain					
	Chest pain		Social History:			
	Palpitations		Do you Smoke Regularly? ___ Yes ___ No			
	Heart murmur		Cigarettes___ Pipe___ Cigars ___			
Respiratory	Swelling in legs		How often per Day___			
	Shortness of breath		For How Long? ___ Days / Months / Years			
	Cough		Do You Drink Alcohol? ___ Regularly? ___ Yes ___ No ___			
Gastrointestinal	Asthma		Beer ___ Wine ___ Hard Liquor ___			
	Reflux/heart burn		How much Per Day? ___			
	Nausea		How Many Per Week? ___			
	Vomiting		Do you use any street drugs? ___ Yes ___ No			
	Constipation		Are you, or have you been addicted to any drugs or alcohol?			
	Diarrhea		___ Yes ___ No			
	Abdominal pain		Any blood transfusions? ___ Yes ___ No			
Urologic	Bowel incontinence		Tattoos? ___ Yes ___ No			
	Urinary hesitancy/dribbling		Risky sexual activity for STDs? ___ Yes ___ No			
	If Male, Prostate Disorder?		What is your current job? _____			
	Kidney stones		If Retired, what did you do prior to retirement? _____			
Endocrine	Pain during urination					
	Diabetes					
Hematologic	Thyroid Disorder		What is your highest level of education? _____			
	Anemia					
	Easy bruising		Are you: Single / Married / Divorced / Widowed			
For Doctor's Use Only: Date _____						
Reviewed By: _____						

FAMILY HISTORY:

Are you Adopted? _____

Family History	If Alive is health good/fair/poor? And list any illnesses	Age	Cause of Death
Father			
Mother			
Siblings			
(List Individually)			
Children			
(List Individually)			

Any blood relative who has had the following (list each relative - e.g. Mother, paternal grandfather, etc):

Similar type of illness that you currently have	
Stroke	
Alzheimer's or dementia	
Migraines	
Seizure disorder or epilepsy	
Muscle Disease	
Nerve Disease or neuropathy	
Tremor	
Parkinson's Disease	
Heart Disease	
High Blood Pressure	
Diabetes	
Cancer	
Blood Clotting Disorder	
Other	

Patient Scheduling Questionnaire:

1. Have you had a Sleep Study before? (If no skip to #5)
If yes- How long ago?
2. Do you remember where you had the study performed?
3. Were you diagnosed with a sleep disorder?
4. Are you under current treatment for this disorder?
5. Have you ever had a heart attack or stroke?
If yes – Which did you have? When?
6. Do you have a history of lung disease (for example: asthma, chronic bronchitis, COPD)?

Are you on oxygen?
If yes – how many liters per minute?
Are you using oxygen all the time?
7. Can you walk unassisted 50 feet?

If no- Do you use a walker or wheel chair?

What special needs/restrictions do you have?
8. Are you currently taking any stimulant medication like Provigil or Ritalin?

If yes, have you been taking it within the last two weeks?
9. Are you taking sleep medication?
10. Do you have any communicable diseases that our techs need to be aware of?
(TB, Hepatitis C, HIV, etc)



PATIENT INFORMATION
NeuroDiagnostic
Laboratories

Please Print

Today's Date _____

Name _____ Date of Birth _____ Age _____
First Middle Last

Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ Work Phone() _____ Ext _____

Cell Phone () _____ E-mail _____

In case of emergency, name & phone number of nearest relative _____ () _____

Drivers License # and State _____ SS# _____ - _____ - _____

Sex: Male Female Marital Status: S M D W Name of Spouse _____

Primary Care Physician's Name _____ Phone() _____

GUARANTOR INFORMATION – Must be completed (Patient &/or Responsible Party):

Responsible party / Guarantor Name _____ Guarantor Date of Birth ____/____/____

Employer Name _____ Occupation _____

Employer's Address _____ Phone() _____

City & State & Zip _____ SS# _____

WORKER'S COMPENSATION/AUTO ACCIDENT CLAIM: YES NO

Insurance Carrier _____ Carrier Address _____

Claim # _____ DOI: ____/____/____

Adjuster's Name _____ Adjuster's Phone() _____

INSURANCE INFORMATION: PRIMARY (A valid Insurance card is required in order to bill)

Insurance Carrier _____ Insurance Group Number _____

Guarantor on Policy _____ Relationship to Patient: Self Spouse Dependent Other

Insured's Employer _____ Address _____

Insured's SS # _____ Insured's Date of Birth ____/____/____

Plan ID # _____ Plan Effective Date ____/____/____

Annual Deductible Amount \$ _____ Co-Pay Amount \$ _____ Has patient's deductible been met for this year? Y N

Type of Plan: PPO EPO POS HMO Indemnity Other

INSURANCE INFORMATION: SECONDARY (A valid Insurance card is required in order to bill)

Insurance Carrier _____ Insurance Group Number _____

Guarantor on Policy _____ Relationship to Patient: Self Spouse Dependent Other

Insured's Employer _____ Address _____

Insured's SS # _____ Insured's Date of Birth ____/____/____

Plan ID # _____ Plan Effective Date ____/____/____

Annual Deductible Amount \$ _____ Co-Pay Amount \$ _____ Has **patient's** deductible been met for this year? Y N

Type of Plan: PPO EPO POS HMO Indemnity Other

Sleep Consultation

I, _____, have been referred to NeuroDiagnostic Laboratories, LLC/AMDx, LTD for a sleep consultation to determine if I am a candidate for a sleep study.

I understand that the physician will be asking me a series of questions regarding my current condition in order to make an evaluation and recommend possible treatment options.

I authorize the sleep consultation.

Patient's Signature

Date

Witness Signature

FINANCIAL POLICY

Benefits are determined once a claim is received by your insurance company. Our facility will provide the service of billing your medical insurance company; however, as the patient and/or responsible party, you are responsible for providing us with **ALL** the **CORRECT** and **COMPLETE** information regarding medical insurance coverage at the time of service. It is also the responsibility of the patient and/or responsible party to pay for all co-payments, deductibles, and/or co-insurance amounts, if required by your insurance policy. If the insurance company denies the claim for services rendered due to reasons for which we cannot appeal, you understand that the balance will then become your responsibility.

As a cash paying patient, you are aware that half of the payment for services rendered are due at the time of service and payment arrangements may be made for the remaining balance.

A non-sufficient funds (NSF) fee of \$25 will be applied to any returned check and then we will only accept cash, credit card, or money order for any and all payments thereafter.

If you fail to pay any amount owed within the time allotted, your account will be sent to a collections agency and you understand that you will then owe the amount for services rendered plus any and all collection costs and attorneys fees.

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare Beneficiary, to AMDx, LTD/Neurodiagnostic Laboratories, LLC and or/it's affiliated entities or otherwise at its direction.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by AMDx, LTD/Neurodiagnostic Laboratories, LLC. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by AMDx,LTD/Neurodiagnostic Laboratories, LLC.

I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY,
ASSIGNMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE INFORMATION

Print Patient/Responsible Party Name: _____

Date Of Birth: _____

Social Security Number: _____

Patient/Responsible Party Signature: _____

Date: _____

OBSTRUCTIVE SLEEP APNEA

Obstructive Sleep Apnea (OSA) is a common sleep disorder that is caused by obstruction of the airway. The characteristics of OSA are pauses in breathing during sleep. These pauses each last long enough that one or more breaths are missed and occur repeatedly during sleep. In OSA, breathing is interrupted by a physical block to airflow even though the patient is trying to breathe.

There are several treatment options for OSA available and each treatment option varies in effectiveness.

Continuous Positive Airway Pressure (CPAP) machine: delivers a stream of compressed air via a hose to a nasal pillow, nose mask or full-face mask, splinting the airway (keeping it open under air pressure) so that unobstructed breathing becomes possible, reducing and/or preventing apneas and hypopneas. It is important to note that it is the air pressure and not the airflow that prevents the apneas. CPAP is the most effective treatment option available.

The CPAP machine blows air at a prescribed pressure (also called the titrated pressure). The necessary pressure is determined by a sleep physician after reviewing the sleep study that is supervised by a sleep technician in a sleep laboratory. The titrated pressure is the pressure at which most, if not all, apneas and hypopneas are prevented. When first starting out with the CPAP machine, there may be some discomfort but this can easily be overcome with the correct equipment. Make sure you discuss any discomfort or concerns with the physician.

CPAP therapy leads to significant improvement in sleepiness and quality of life, better moods as well as reduced diastolic and systolic blood pressure. In OSA patients that utilize the nasal CPAP machine as prescribed have reduced hospitalization with cardiovascular and pulmonary disease. Patients with diabetes also see improvement with the use of the CPAP machine.

Some additional therapies include:

Positional Therapy – Apneas tend to be worse when sleeping on the back and there are several FDA approved pillows designed to prevent sleeping on the back. Positional alarms are also available and make noise when one begins to sleep on the back; however, they may disrupt the sleep so much that it may become more of a concern than a benefit.

Dental Appliances – are intended to treat apnea by keeping the airway open in one of 3 ways: by pushing the lower jaw forward (a mandibular advancement device or MAD), by preventing the tongue from falling back over the airway (a tongue-retaining device), or by combining both mechanisms. Dental appliances are generally more effective with people that suffer from mild sleep apnea and who are not obese. On occasion they may worsen sleep apnea.

Weight Loss - sleep apnea may be weight related since additional fat around the neck may make the airway narrower, making obstructions more likely to occur. Weight loss for people with mild cases of apnea may be an effective treatment option. For people with more severe apnea, weight loss may be beneficial but may be hard to achieve since the person could be too tired to work out or may eat during

the day to stay awake. In this case, it may be best to use another treatment option while participating in a medically supervised weight loss plan.

Alcohol and medications - that act as central nervous system depressants, such as pain killers, sedatives, and muscle relaxants can worsen sleep apnea by relaxing the airway muscles further and/or by reducing the respiratory drive and causing more apnea to occur. You may want to discuss alternative medications with your physician.

If you are diagnosed with Obstructive Sleep Apnea and a CPAP machine is prescribed as the best treatment option for you, there is a minimum standard of compliance in order to see the benefits. You are required to use the machine for a minimum of 4 hours a night, 70% of nights. Are you willing to comply with this standard if this treatment option is recommended?

Yes _____

No _____

Patient Name: _____

Signature: _____

Date: _____



Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have received a copy of American Medical Diagnostics Ltd (AMDX)/NeuroDiagnostic Laboratories, LLC (NDL) Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in AMDX/NDL's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the AMDX/NDL Patient Privacy Officer as indicated on your Notice.

Patient Name (Printed): _____

If Patient Representative, Name (Printed): _____

If Patient Representative, Relationship to Patient (Printed): _____

Signature: _____

Date Notice Received: _____