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You are scheduled for a sleep study on: _____ at _____.

Please review and complete the following forms as completely as possible prior to your sleep study:

- Patient Questionnaire
- Sleep Diary
- Bed Partner Questionnaire, if applicable

Instructions for the day of your sleep study:

Do

- ✓ Do bring your regular, prescribed medications to take according to your physician's instructions
- ✓ Do bring sleeping clothes such as pajamas or shorts and t-shirt
- ✓ Do bathe and have your evening meal prior to coming to the sleep clinic
- ✓ Do bring a favorite pillow or blanket if desired
- ✓ Do bring reading material if desired

Do Not

- ✓ Do not take any naps during the day
- ✓ Do not drink or eat anything containing caffeine such as coffee, chocolate, tea, soda, etc. after 11:00am
- ✓ Do not use hair sprays, leave in conditioners or hair oils

What to expect when you arrive for your sleep study:

When you arrive at the clinic a sleep technologist will help you complete any additional paperwork, explain the testing procedure, and answer any questions you may have. The sleep technologist will then apply several sensors to record brain activity, eye movements, muscle movements, heart rate, and other parameters. All of the sensors are completely non-invasive and painless. You will sleep in a private, comfortable room with a restroom available nearby. The technologist will be in the clinic throughout testing to provide for your safety and monitor the recording. A minimum of six hours of recording time is necessary, and no electronic items such as radios, TVs, cell phones, etc. are allowed to be used once the study has begun.

What to expect when you receive your bill:

A Sleep Physician will analyze and interpret the sleep study results. The charge for this interpretation is separate and will be in addition to the charges for the sleep study. Any additional medical supplies such as CPAP equipment will also be billed separately.



Have you ever had a sleep study? Yes No

If you answered yes, please provide a copy of your sleep study records if possible. Please bring your current CPAP or Bilevel machine and mask if applicable, and answer the following questions:

When was your previous sleep study? _____

Where was your previous sleep study? _____

What were the study results? _____

Are you currently using CPAP or a Bilevel machine at home? Yes No

If yes, what is your treatment setting? _____

Please indicate the brand, model and age of the machine: _____

Do you expect to be replacing your old machine? Yes No

What type of mask are you using, how old is it, and are you happy with its performance?

Please describe why you need a sleep study at this time:



Patient Questionnaire

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Marital Status: _____ Referring Physician _____

Why Are You Here? (Reason for the study in your own words): _____

Occupation: _____

Sleep Schedule

- 1. What time on weekdays do you usually Go to bed? _____ Wake up? _____
What are your usual working hours if applicable Begin? _____ End? _____
2. What time on weekends do you usually Go to bed? _____ Wake up? _____
3. On average, how long do you actually sleep at night? Weekdays? _____ Weekends? _____
4. Do you feel that you get too much or too little sleep at night Too much? _____ Too little? _____

Night Time Symptoms

- 5. How long does it normally take you to fall asleep at night? Mins _____
6. Do you have thoughts that prevent sleep? Yes _____ No _____
7. Do you have trouble getting to sleep at night? Yes _____ No _____
8. Do you awaken at night to use the bathroom? Yes _____ No _____ How often? _____
9. Are you ever awakened by a "coughing spell" during the night? Yes _____ No _____
10. Do you have crawling sensations in your legs while falling asleep? Yes _____ No _____
11. Do you have twitching movements in your legs during the night? Yes _____ No _____
12. Do you awaken with racing thoughts, sadness or anxiety? Yes _____ No _____
13. Have other people told you that you have restless sleep? Yes _____ No _____
14. Do you have difficulty going back to sleep during the night? Yes _____ No _____
15. Does anyone tell you, you snore badly? Yes _____ No _____
16. Do you have difficulty breathing at night? Yes _____ No _____
17. Do you wake up with headaches? Yes _____ No _____ How often? _____
18. Do you awaken with a sour or bitter taste in your mouth? Yes _____ No _____ How often? _____
19. Is it difficult for you to awaken and get out of bed after sleeping? Yes _____ No _____ How often? _____
20. Have you experienced paralysis upon awakening from sleep? Yes _____ No _____ How often? _____
21. Do you have vivid dreams as you are falling asleep? Yes _____ No _____ How often? _____
22. Is your sleep disturbed by a medical problem (Y/N)? _____; Describe: _____

Day Time Symptoms

- 23. Do you deliberately take naps during the day Yes ___ No _____ How often? _____ How Long _____
24. Do you feel rested or refreshed after a nap? Yes _____ No _____
25. Are you bothered by sleepiness during the day? Yes _____ No _____ How often? _____
26. Do you find yourself falling asleep when you don't mean to? Yes _____ No _____ How Long _____
27. Do you take naps during the day? No Need _____ I want to but can't _____ Number of times a week _____

28. Do you fall asleep during these situations?

0 = no chance of dozing, 1 = slight chance of dozing, 2 = moderate chance of dozing, 3 = high chance of dozing
Sitting and reading 0 1 2 3
Watching TV 0 1 2 3
Sitting inactive in a public place? 0 1 2 3
As a passenger in a car for an hour with out 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

_____ Total

29. Have you noticed, or been told about, any changes in your personality recently, such as:
- | | | | |
|---------------------|--------------------|-------------------------------|--------------------|
| a) irritability | Yes _____ No _____ | e) loss of concentration | Yes _____ No _____ |
| b) increased temper | Yes _____ No _____ | f) "spaced out" feeling | Yes _____ No _____ |
| c) anxiety | Yes _____ No _____ | g) decreased job productivity | Yes _____ No _____ |
| d) depression | Yes _____ No _____ | h) poor memory | Yes _____ No _____ |

30. Have you ever had the following kinds of weakness develop suddenly during an emotional situation (for example, when laughing, if angry, if in an exciting situation, etc.)? (Check one on each line):

	Never	1-5 times in your life	Monthly	Weekly	Daily - almost daily
Knees buckling					
Mouth opening					
Head nodding					
Falling down					

Do you know, or others tell you that you:	Age Started	Last Occurred	Frequency	Treatment
Talk while apparently asleep?				
Walk while apparently asleep?				
Grit teeth while apparently asleep?				
Wake up screaming, anxious or afraid?				
Have disturbing dreams (nightmares)?				
Have unusual movements while asleep?				

Health History

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus Surgery | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Neurologic Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Colitis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> Deviated nasal septum | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Dementia | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Fibromyalgia |
| | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Parkinson's |

31. Please list any other health or surgical history _____

If anyone in your family had sleep problems, please list the problem & your relationship _____

Medications Please list below or attach to the back of this questionnaire

Medications	Amount	How Often	Years	Reason	Medications	Amount	How Often	Years	Reason

32. For each of the beverages listed below, please write the average amount you drink daily:

Regular coffee(Cups)_____ Hot or iced tea (Cups) _____ Caffeinated soft drinks ____

33. Do you smoke cigarettes (Y/N)? _____ If YES, how many packs per day? _____ For how many years? _____

34. If NO, did you ever smoke (Y/N)? _____ When did you stop smoking? _____

35. How many alcoholic beverages do you drink per day on weekdays _____ / weekends? _____ or per month _____

If there are any other aspects that you feel are important, please describe them here or on the back of this page.



Sleep Diary

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Date:							
I went to bed last night at ____:____ (time):							
I got out of bed at ____:____(time):							
Last night, I fell asleep in ____ (Mins):							
When I woke up for the day I felt:	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued
Last night I woke up ____ times:							
My sleep was disturbed by:							
Number of caffeinated beverages in the morning:							
Number of caffeinated beverages in the afternoon:							
Number of caffeinated beverages in the evening:							
I exercised 20 mins or more at ____:____ (Time):							
Number of alcoholic beverages before bedtime:							
Medications I took during the day:							
I did what activity within an hour before bed:							



Bed Partner Questionnaire

Patient Name: _____ Date: _____

Your Name: _____ Relationship: _____

I have observed this person's sleep (circle one): Never Once or twice Often Every night

Check any of the following behaviors that you have observed this person doing while asleep. Circle those that you consider severe problems.

- | | |
|---|--|
| <input type="checkbox"/> Light snorer | <input type="checkbox"/> Becoming very rigid and shaking |
| <input type="checkbox"/> Moderate snorer | <input type="checkbox"/> Apparently sleeping even if he/she says otherwise |
| <input type="checkbox"/> Loud snorer | <input type="checkbox"/> Twitching or kicking of legs |
| <input type="checkbox"/> Occasional loud snorts | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Choking | <input type="checkbox"/> Sitting up in bed not awake |
| <input type="checkbox"/> Pauses in breathing | <input type="checkbox"/> Head rocking or banging |
| <input type="checkbox"/> Sleep talking | <input type="checkbox"/> Biting tongue |
| <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Crying out |
| <input type="checkbox"/> Awakening with pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Getting out of bed not awake | |

If this person snores, what makes it worse?

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Sleeping on his/her back | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sleeping on his/her side | <input type="checkbox"/> Alcohol |

Please describe the behaviors checked in more detail. Describe the time when it occurs, how often it occurs during the night, and whether it occurs every night.

Has this person fallen asleep during normal daytime activities or in dangerous situations? Yes / No

If yes, please explain: _____

Does this person use sleeping pills? Yes / No What kind? _____ How often? _____

Does this person drink alcohol? Yes / No Please estimate the per (week night/weekend night) use of:

___/___ 12 oz. Bottle/can/tap beer ___/___ 6-8 oz. Glasses of wine ___/___ 1-1/2 oz bottle/cap/tap liquor

Please estimate how much alcohol this person consumes in the 3 hours before bed: _____

If this person uses recreational drugs, please describe both the types and frequency of usage: _____



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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your care and treatment. As a courtesy we will bill your insurance. Deductible and co-pays are due at the time of service.

Your insurance policy is a contract between you and your insurance company. Some of our services provided may be non-covered services and not considered necessary under Medicare or other insurance companies. We suggest that you call your insurance carrier if you have any concerns or questions regarding your particular coverage.

Any amount your insurance company does not cover is your responsibility. I acknowledge that lack of payment to my account may result in being turned over to a collections agency and subject to a 40% collectors fee.

I have read and understand this Financial Policy.

Signature of Patient or Responsible Party

Date

Print Name

Due to HIPPA regulations, we are unable to talk to anyone but the patient regarding their financial account without a signed release. If you would like us to talk with anyone regarding your account, please list his or her name(s) and sign the form below.

I hereby authorize _____
to speak with the staff of Alaska Sleep Clinic regarding my financial account. I understand that if I want to change this release, I must do so in writing.

Signature of Patient or Responsible Party

Date



Release for Photograph and Video Recording for Medical Purposes

In order to collect a complete and detailed sleep study that will enable the physician(s) providing my care to effectively diagnose and treat my sleep condition, I, the undersigned, consent and authorize photographic, video, and/or audio data to be recorded during the testing procedure.

Signature: _____ Date: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____

Release for Photograph and Video Recording for Educational Purposes

I further authorize the subsequent use of my photographic, video, and/or audio recording to be used for the furtherance of medical science and/or for medical education purposes. I consent to the presentation of all relevant medical information and clinical demonstration concerning my/this case to students of medicine and allied health sciences, to medical professional groups, and to possible publication thereof in scientific literature. Anonymity will be insured.

Signature: _____ Date: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____



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Sleepy Driver Warning

Sleepiness causes auto crashes because it impairs your reaction time and attention and ultimately can lead to you falling asleep at the wheel.

Although no driver is immune to drowsy driving-related accidents, there are higher risks to some populations. People with untreated sleep apnea, narcolepsy or other sleep disorders are at higher risk for driving-related accidents.

Upon completion of a physician directed sleep disorders test performed at **Alaska Sleep Clinic** you have been provided written explanation of the consequences and are hereby advised against driving until such time as you have been evaluated, diagnosed and successfully treated by a physician for any sleep disorder that can impair your ability to safely operate a motor vehicle, and until such time as all symptoms of excessive sleepiness have been successfully resolved.

Print Name: _____

Signature: _____ Date: _____



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Warning of Sleep Apnea Related Accidents and Health Risks

Your sleep study may indicate that you have severe sleep apnea. This is often associated with excessive daytime sleepiness. **This notification is to warn you that you are at risk of experiencing sudden brief microbursts of sleep.** These episodes, often experienced as a brief head bob, are associated with severely impaired ability to safely operate a motor vehicle or other dangerous machinery. Patients with sleep apnea have been shown to have a very high risk of auto accidents which may be as much as nine (9) times that of a healthy alert person, and three (3) times the risk of the general population. Even brief lapses in alertness can allow an auto to travel over 300 feet while the driver is unable to react to changing situations. This can result in severe and fatal accidents.

We recommend that you do not drive until your sleep problem is corrected. You may drive once you have been successful at sleeping with a corrective CPAP or other sleep aid equipment for three to four nights. We recognize that this recommendation may be a significant inconvenience for you, but it is intended to keep you, your family, and the public, safe and free from risk of injury or death. We suggest you car pool to and from work, and avoid working with dangerous machinery until this issue is resolved. While we do not report this information to the Alaska Department of Motor Vehicles as it is not required that we do so, we do request you comply with this recommendation. Following these instructions may save your life, or the life of someone you love.

In addition, there are severe medical risks related to sleep apnea. Patients have increased risk of high blood pressure, heart attacks, strokes, and weakness of the heart due to sleep apnea. These risks usually increase slowly over many years. Rarely, patients may experience sudden heart rhythm disturbances, including sudden death at night. The frequency of this is very low. **Please keep your follow up appointment so that we can discuss this further and start therapy if indicated.**

Sincerely,

John Krehlik, M.D.
Medical Director
Alaska Sleep Clinic