HPI COMMUNITY HOSPITAL

Scheduled Appointment Information

Your physician ordered sleep study has been scheduled as follows:

Date and Time: ________________________at 8:30 pm
Location: 3100 SW 89th Street, OKC, OK 73159

We are located on SW 89th Street, between May Ave, and I-44. Please arrive at 8:30 pm at the East Side of the building. Check in through the pain Center. Once you are checked in the technician will arrive to escort you to the sleep disorder center. **PLEASE NOTE THAT A TECHNICIAN WILL NOT ARRIVE UNTIL 8:30PM.**

IMPORTANT: **Patients who require assistance from a caregiver must have the caregiver present at all times. CAREGIVERS will be required to stay with the patient for the duration of the study.**

*** Reminder:** No nap or caffeine after 12 pm the day of your study. Please eat your evening meal at least 2 hours prior to your scheduled test time. Do not consume any Alcohol 24 hours prior to the test.

*** IMPORTANT: You must cancel or reschedule 24 hours before your set appointment or you will be charged a technician fee of $250.00. To receive a refund of the fee, all appointments must be rescheduled within 72 hours of the original scheduled appointment and you must attend the newly scheduled appointment.**

Things to bring:

1. The enclosed questionnaire – (please complete prior to arrival)
2. Something loose fitting and comfortable to sleep in, as well as, a robe and slippers.
3. All medications that you are currently taking - (please have them written down prior to arrival)
4. Your insurance card and two forms of identification including a picture I.D.

Things to remember:

1. Questions regarding your medications should be referred to your physician.
2. Your hair **must** be clean and free of gels and hair spray materials.
3. We have pillows; however, please feel free to bring your own to add to your comfort.
4. Bring an overnight bag with the items you would normally use for an overnight stay.
5. Smoking materials, tobacco, and firearms are prohibited in our facility.

Insurance and Financial Responsibility:

If you have any questions regarding your insurance please feel free to call Community Hospital at **602-8100.** You will be responsible for the actual contracted amount if the claim is not paid in full. We urge you to contact your insurance provider member services to verify the information above.

If you have any questions about this sleep study or any information contained in this letter, please contact us prior to your appointment. Our Patient Care Coordinator will be happy to answer any questions you may have -- (405) 949-0060 M-F 8-5.

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Place Label Here

SLEEP QUESTIONNAIRE

Patient Name: _________________________ Date: _____________

Date of Birth: _____________ Sex: (circle one) M F Height: ______ Weight: ________

Referring Physician: ______________________ Primary Care Physician: ______________

Welcome to our sleep clinic. The following questions will help us understand more about you and your possible symptoms. Please answer the questions as frankly and accurately as possible as they relate to the last 12 months. Do not leave any question unanswered.

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Main Complaint (Please describe): ____

How long have you had this problem? About _____ years

Have you ever seen a physician for this problem? Yes __ No ___

Have you ever had a sleep study before? Yes ___ No ___

If yes, when and where: ____

Do you have a CPAP or BiPAP machine? Yes ___ No ___ How much do you use the machine? _____________

Do you use O_2 at home? Yes ___ No ___ Night Time O_2 use: Yes ___ No ___

What is your normal bedtime? (When you try to go to sleep, although you may not actually fall asleep until later)
____

How long does it usually take you to fall asleep? ____

Do you awaken often during the night? Yes ___ No ___ How many times: _______
If yes, why? ____

What time do you get up in the morning? __________ Do you feel refreshed? _____

Do you usually nap during the day? Yes ___ No ___

Do you work different shifts? Yes ___ No ___ What shift? ____________

Circle the appropriate responses

I have high blood pressure:	Yes / No	I have diabetes:	Yes / No
I have an irregular heartbeat:	Yes / No	I have asthma:	Yes / No
I have had a stroke or TIA:	Yes / No	I have heartburn at night:	Yes / No
I have history of congestive heart failure:	Yes / No	I have seizures:	Yes / No
I have had a heart attack:	Yes / No	I have COPD:	Yes / No

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Please answer the following questions using this scale (consult bed partner):
0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Frequently 5 = Always

0 1 2 3 4 5 I have been told that I snore.

0 1 2 3 4 5 Others cannot sleep in the same room because I snore loudly.

0 1 2 3 4 5 I have been told that I stop breathing while asleep.

0 1 2 3 4 5 I do not feel refreshed when I awaken.

0 1 2 3 4 5 I have to take naps during the day.

0 1 2 3 4 5 I have problems with my performance at work because of fatigue and tiredness.

0 1 2 3 4 5 I sometimes fall asleep at inappropriate times.

0 1 2 3 4 5 I fall asleep at work.

0 1 2 3 4 5 I fall asleep at meetings.

0 1 2 3 4 5 I have fallen asleep while driving.

0 1 2 3 4 5 I awaken with headaches.

0 1 2 3 4 5 I sweat at night.

0 1 2 3 4 5 I have awakened during the night choking.

0 1 2 3 4 5 I have trouble getting to sleep at night.

0 1 2 3 4 5 I have trouble staying asleep at night.

0 1 2 3 4 5 I have been told I kick during my sleep.

0 1 2 3 4 5 I have an aching or crawling sensation in my legs in the evening.

0 1 2 3 4 5 The aching or crawling sensation in my legs worsens if I keep my legs still.

0 1 2 3 4 5 The unpleasant sensations in my legs improve with activity.

0 1 2 3 4 5 I eat in my sleep.

0 1 2 3 4 5 I have been told I walk in my sleep.

0 1 2 3 4 5 I have been told I talk in my sleep.

0 1 2 3 4 5 When I laugh or get angry, I feel like I am going limp. (getting weak)

0 1 2 3 4 5 When I am falling asleep or awakening, I am paralyzed and unable to move.

0 1 2 3 4 5 I have vivid dreams or hallucinations as I go to sleep or wake up.

0 1 2 3 4 5 I have been told I act out my dreams.

0 1 2 3 4 5 I have nightmares.

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Place Label Here

How much caffeine do you consume daily? Coffee (cups) ______ Cola/Tea: _______

Do you drink caffeine in the evening? Yes ___ No __ Do you drink alcohol before bedtime? Yes ___ No ___
Kind and Amount: _____________________________

Serious Medical Problems and Surgeries (with dates)

____
____
____
____
____
____
____
____
____
____
____

List all medications you are currently using:

Name of Medication	Dose & Frequency	Last time medication was taken?	Name of Medication	Dose & Frequency	Last time medication was taken

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Name: ______________________

Date: ______________________

EPWORTH SLEEPINESS SCALE

How likely are you to fall asleep or doze in the circumstances listed below? When rating these situations, give the highest consideration to recent events. If you have never experienced one of these situations, estimate how you might have reacted.

0 = no chance

1 = slight chance
2 = moderate chance
3 = high chance

SITUATION:

Sitting and reading	______
Watching television	______
Sitting inactive in a public place (i.e. theater or meeting)	______
As a passenger in a car for an hour without a break	______
Lying down to rest in the afternoon when circumstances permit	______
Sitting and talking quietly to someone	______
Sitting quietly after lunch without alcohol	______
In a car while stopped for a few minutes in traffic	______
TOTAL:	______

PLACE
LABEL
HERE

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Patient Information:

Patient Name: ____ DOB: ________Age: ______________

Address: _______________________________ City: ____________________ Zip: ______________

Home Phone: ________________ Work:_____________________ Cell: ______________________

Ht______ LBS__________ Referring Physician_________________________________

Primary Care Physician_______________________ Phone Number ________________

SS#: ___________________________________ Gender: ☐ Male ☐ Female
Marital Status ☐S ☐M ☐D ☐W

Email address: _________________________________

Insurance Information: **Please provide our office with a copy of your insurance card.**

Primary Insurance Carrier:__________________________ Phone: __________________________

ID #: _______________________________ Policy Group #: ________________________________

Policy Holder: _________________________________ Relationship to Patient: __________________

Policy Holder's Date of Birth: _____________________ Policy Holder's SS#: ____________________

Secondary Insurance Carrier:________________________ Phone: __________________________

ID #: _______________________________ Policy Group #: ________________________________

Policy Holder: _________________________________ Relationship to Patient: __________________

Policy Holder's Date of Birth: _____________________ Policy Holder's SS#: ____________________

Employment Information:

Employer_______________________________ Work Ph#: _______________________

If the patient is a minor, please list guardian information:

Guardian: _______________________________ Phone #: ________________________

Third Party Billing:

Is your injury work related?	☐**Yes**	☐**No**
Is this injury due to an accident?	☐**Yes**	☐**No**
If your injury is MVA related, have you obtained an accident report?	☐**Yes**	☐**No**

Injury date or Date of Occurrence:____________________________.

Emergency Contact:

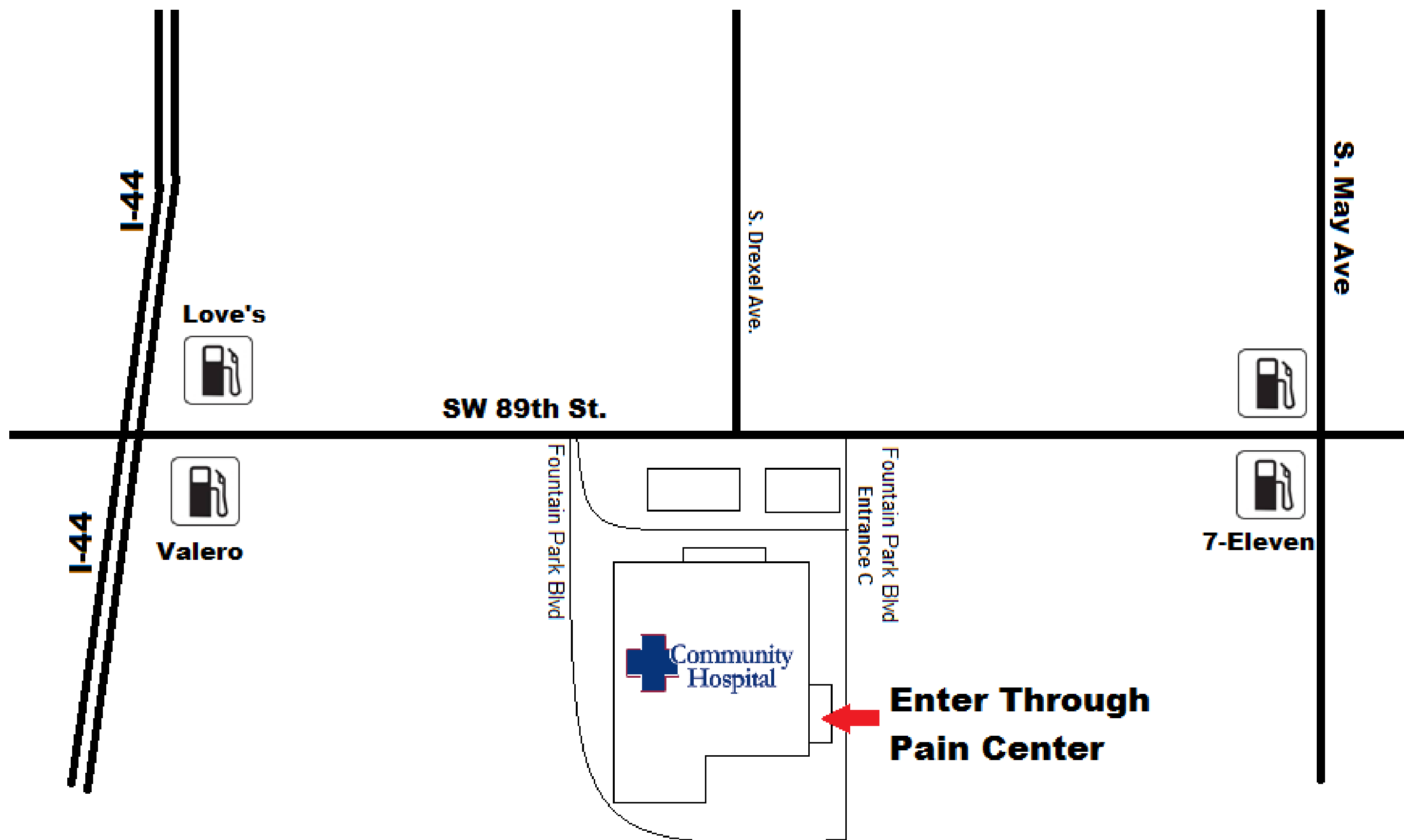
Name: ____ Relationship: ____________________

Phone: ____________________________________

Signature: ____ Date: __________________

Directions to Community Hospital

3100 SW 89th Street. Enter Through East Doors (Pain/Sleep Center)
We are located on SW 89th between S. May and I-44



From Newcastle/Tuttle:

1. Take I-44 towards Oklahoma City
2. Exit on SW 89th (exit 113)
3. Turn Right onto SW 89th, going east
4. Turn Right on Fountain Park Blvd **Entrance C**
5. Enter through **Pain Center** Doors on **east** side of hospital

If you need additional directions or are lost after hours, please call (405)600-1202

From Del City/ Midwest City:

1. Take **I-240** going **west** towards Oklahoma City (points on north I-35, take I-35 south to I-240)
2. Exit on **May Ave** and turn **left**, going **south**
3. Turn right onto **SW 89th St**.
4. Turn left on Fountain Park Blvd **Entrance C** into Community Hospital
5. Enter through **Pain Center** Doors on **east** side of hospital

From Northwest Oklahoma City:

1. Take I-44 towards Lawton, going **south**. (From Yukon take I-40 to I-44)
2. Exit on SW 89th St. (Exit 113)
3. Turn Left onto SW 89th, going **east**
4. Turn Right on Fountain Park Blvd **Entrance C**
5. Enter through **Pain Center** Doors on **east** side of hospital