PULMONARY & SLEEP SPECIALISTS

Clermont Sleep Center

THE EPWORTH SLEEPINESS SCALE

Today's Date: _____

Name: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 have affected you. Use the following scale to choose the *most appropriate* number for each situation. Please mark the appropriate box below.

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situations ***Chance of dozing***

	0	1	2	3
In a car, while stopped for a few minutes in traffic				
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g. theater or a 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 to someone				
Sitting quietly after a lunch without alcohol				

EPWORTH SCORE: (Total of all answers combined): _____
*** A score of 10 or higher is an indication of excessive sleepiness and indicates that you may benefit from further evaluation.**

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Pulmonary, Critical Care & Sleep Specialists
Registration Form

Patient Name: _____ DOB: _____Phone Number: _____

CONSENT FOR MEDICAL DIAGNOSTIC PROCEDURES:

I authorize Pulmonary, Critical Care & Sleep Specialists to perform the necessary medical diagnostic procedures ordered by my physician.

AUTHORIZATION OF RELEASE OF INFORMATION:

I certify the information that I have provided is correct. I authorize the release of medical information to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

ASSIGNMENT OF BENEFITS:

I request that payment under Medical Insurance Program be made directly to Pulmonary, Critical Care & Sleep Specialists for services by that provider. I further authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medical Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment, in this case Pulmonary, Critical Care & Sleep Specialists. The patient is responsible for any deductibles that are required as per Medicare or any other insurance policies. If Medicare or other carrier denies payment, it is the patient's responsibility to pay the full amount of purchase or rental. I acknowledge that I have read and understand all of the terms, and I have received a completed copy of this.

CONSENT TO PHOTOGRAPH AND/OR RECORD AUDIO AND VIDEO:

I,_____(Patient/Guardian) hereby authorize Pulmonary, Critical Care & Sleep Specialists, or their representative, to take photograph(s) and/or record audio and video of _____(Name of Patient). I understand that such photograph(s), audio recording(s) and /or video recordings are used for clinical purposes or in the event of legal action. Pulmonary, Critical Care & Sleep Specialists and trustees of Pulmonary, Critical Care & Sleep Specialists and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video. The undersigned also hereby transfers and assigns to Pulmonary, Critical Care & Sleep Specialists the right to copy the material in whole or in part.

PATIENT CONFIDENTIALITY RELEASE: The Health Information Portability and Accountability Act (HIPAA) is a federal privacy law limiting the transfer of personal health information to others than the individual patient. This is a privacy protection measure. We frequently utilize telephone contact to inform patients of the results or to discuss scheduling issues. Please list the people to whom we may speak regarding your medical information, or fax information to and their relationship to you.

Name: _____Relationship: _____
Name: _____ Relationship: _____

If we are unable to discuss your results with you after your study and are unable to reach you directly by telephone, may we have your specific permission to leave messages. Please indicate how we may leave you a message by placing a check in the box next to your preference(s). Cell Phone ☐ Personal Voicemail ☐ Home Answering Service ☐ Work Voicemail ☐ Other ☐

WAIVER OF LIABILITY:

As per the orders of your physician, warranting the necessity of a sleep study, you should understand that you may be diagnosed with a sleep disorder. Understand that such a diagnosis, without proper treatment, may impair your ability to drive or operate heavy machinery. You are cautioned not to drive or operate heavy machinery until you are under the appropriate treatment for your diagnosis. By signing, you release Pulmonary, Critical Care & Sleep Specialists from such liability as a result of your diagnosis and understand that if you choose to drive or operate heavy machinery it should be done so with extreme caution. Additionally, Pulmonary, Critical Care & Sleep Specialists are not responsible for any lost, stolen or damaged personal property brought to our facility by patients or caregivers. Pulmonary, Critical Care & Sleep Specialists does not honor Advanced Directives in the event of a medical emergency, we will call 911 and begin appropriate life saving measures.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, HAS HAD THE OPPORTUNITY TO ASK QUESTIONS, IT THE PATIENT OR PARENT OF THE PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE OF THE PATIENT, AND THE TERMS OF THIS CONSENT ARE ACCEPTED.

_____	_____	_____	_____
Print Name of Patient	Signature of Patient/Guardian	Date	Signature of Sleep Lab Representative

SLEEP QUESTIONNAIRE

PLEASE RATE HOW OFTEN YOU:	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Constantly**
Suddenly wake up gasping for breath and /or hear yourself snore or snort					
Awaken at night with heartburn, belching or with cough or wheezing					
Snore					
Snore loud enough that others complain					
Have breathing problems during the night					
	Never	**Rarely**	**Sometimes**	**Frequently**	**Constantly**
Notice your heart pounding or beating irregularly during the night					
Experience excessive or troubling daytime sleepiness					
Experience excessive or troubling daytime fatigue or tiredness					
Fall asleep while driving					
Feel generally refreshed upon awakening					
Fall asleep during physical activity					
Fall asleep when laughing or crying					
Experience muscle weakness when extremely emotional					
Have trouble at work or school because of sleepiness					
Feel unable to move (paralyzed) when waking up or falling asleep					
Experience vivid dreamlike scenes upon waking up or falling asleep					
Have nightmares					
Remember your dreams					
Feel anxious, sad, or depressed					
Kick during the night					
Experience crawling and aching feelings in your legs					
Experience troubling discomfort during the night					
Experience any type of pain during the night					
Have morning jaw pain					
Grind teeth during sleep					