REM DIAGNOSTICS
SPECIALISTS IN SLEEP

How to prepare for your sleep study?

1. Before the study, you will need to shower and wash and dry your hair.
2. Do not use conditioners, hair spray, oils or makeup, as the electrodes need to have good contact with your skin.
3. Consult your physicians regarding your medications, but usually you will maintain your regular regimen. Contact your doctor to obtain a sleep aid if you feel that you will be unable to sleep. *If you choose to use a sleep aid, you must arrange alternate transportation after the sleep test has been completed.*
4. Do not engage in heavy exercise or drink alcohol or caffeinated beverages within eight (8) hours of the study.
5. You will be assigned a private room with a queen bed. Bring your sleepwear and any items that make you feel comfortable, such as your favorite pillow. Please leave valuables and jewelry at home.
6. **Bring**
    a. **Photo ID**
    b. **Insurance Card**
    c. **Patient Registration Form**
    d. **Medication List**
    e. **Partner or Roommate questionnaire**
    f. **Epworth Sleepiness Scale and Sleep History Questionnaire**

What can you expect during the sleep study?

1. Our facility follows CDC guidelines for cleanliness and sanitation. Upon request, we are happy to provide you with detailed information on cleaning and disinfections protocols designed to protect the health of patients and staff.
2. **Masks are required to enter the sleep laboratory facility and must be worn in all common areas.** Patients will remove masks while in their private rooms.
3. **You are required to complete a health questionnaire of Covid-19 symptoms and temperature check upon arrival.**
4. You will be asked to review and sign a Conditions of Consent for Treatment.
5. Our staff will be wearing a mask at all times during any interaction and personal protective equipment (PPE) when preparing you for the sleep test.
6. This is a diagnostic test ordered by your physician. The technologist will connect electrodes designed to record various parameters while you sleep. They are not painful or uncomfortable. Please visit www.remdiagnosticsinc.com for more information about sleep studies.
7. You will be assigned a designated bathroom *for your use only.* Use only this bathroom during your sleep visit.
8. Your sleep study will be completed and you will be awakened and discharged between 5:00 am to 6:00 am.
9. We recommend that you schedule a follow-up visit with your doctor approximately three (3) weeks after your sleep study.

Insurance Billing

1. It is your primary care physician's (PCP) responsibility to obtain any required insurance authorizations.
2. It is your responsibility to understand the terms and payments described by your insurance plan and any co-insurance, co-pay, and/or deductible obligations.
3. The sleep lab will bill your insurance for both the technical sleep lab study and the professional interpretation performed by a physician.
4. If your insurance changes prior to your appointment/study, please contact our office immediately, to determine if authorization will be required. Failure to do so may result in denial of your services and would become patients responsibility due in full.
5. To reschedule contact the office within two business days prior to your scheduled sleep study. **There is a fee of $150.00 for any no-show appointments.**

_____ _____

Patient Name (Printed) Date

_____

Patient Name (Signature)

Patient Registration and Insurance Information

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Patient Information

Name _____

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Home Phone _____ Cell Phone _____

Email _____

Street Address _____

Mailing Address _____

Driver's License # _____ Marital Status _____ Employment Status _____

Employer_____ Work Phone _____

Emergency Contact _____ Emergency Phone _____

Referring Physician _____ Primary Care Physician _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Subscriber Name _____ Subscriber Name _____

Subscriber DOB _____ Subscriber DOB _____

ID # _____ ID #_____

Group # _____ Group # _____

Claims Address _____ Claims Address _____

City/State/Zip _____ City/State/Zip _____

Patient Signature/Guarantor _____ Date _____

Printed Name _____ Relationship to Patient _____

PLEASE COMPLETE ENTIRE FORM

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Medication List

Patient Name: _____ **Date:** _____

Medication	Taken For

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Spouse or Roommate Questionnaire

Patient Name: _____ **Date:** _____

Please check any of the following behaviors that you have observed the patient doing while they are asleep:

- ☐ Loud Snoring
- ☐ Light Snoring
- ☐ Twitching of the legs or feet during sleep
- ☐ Pauses in breathing
- ☐ Grinding Teeth
- ☐ Sleep Walking
- ☐ Bed Wetting
- ☐ Sitting up in bed but not awake
- ☐ Head rocking or banging
- ☐ Kicking with legs during sleep
- ☐ Getting out of bed but not awake
- ☐ Biting tongue
- ☐ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) checked above? _____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time of night when it occurs, its frequency, and whether it occurs every night. Please describe if activities occur during certain positions:

_____

_____

_____

If you hear load snoring, do you remember hearing pauses in the snoring or occasional loud “snorts”?

_____

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Sleep History Questionnaire

Patient Name: _____ **Date:** _____

Age: _____ **Height:** _____ **Weight:** _____

Usual Sleep Habits:

Bed Time**:** _____ Number of times awake to urinate, etc.**:** _____

Wake Time**:** _____ Number of naps per week**:** _____ Collar Size**:** _____

Check all that apply:

_____ Excessive Daytime Sleepiness as evidenced by:

_____ 1. Inappropriate Napping

_____ 2. Sleepiness Interferes with activities

_____ Choking sensation associated with awakening

_____ Non-rested upon awakening

_____ Loud Snoring

_____ Restless Sleep

_____ Trouble with Concentration

_____ Witnessed Apnea (stop breathing) while asleep

_____ Awaken with headache

_____ Vivid Dreams

_____ Dreams or hallucinations while awake

_____ Paralysis or inability to move upon awakening

_____ Sudden feeling of weakness in legs

_____ Excessive Movement During Sleep

_____Legs jerk during sleep

_____Jaws ache in morning

_____Teeth Grinding

_____Trouble initiating Sleep

_____ Creeping or crawling sensation in legs

_____ Caffeine consumption

If yes, amount per day/week? _____

_____ Alcohol consumption prior to bedtime

If yes, amount per day/week? __

Current Medical History:

_____ High Blood Pressure

_____ Gained 10 pounds within past year

_____ Coronary Artery Disease

_____ Diabetes

_____ Mood Disorder

_____ Stroke

Current Medical Treatment:

List all conditions for which you are currently or have received treatment for in the last two years:

_____

_____

_____

Previous surgeries and approximate dates:

_____

_____

_____

Previous Sleep Study? Yes / No Currently use CPAP? Yes / No If yes, list pressure: _____

Other Nighttime Symptoms:

_____

_____

EPWORTH SLEEPINESS SCALE

Name: _____

Date: _____ Your Age: _____ Sex: _____

How likely are you to dose 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 <u>most appropriate number</u> for each situation:

0 = would <u>never</u> doze

1 = <u>slight</u> chance of dozing

2 = <u>moderate</u> chance of dozing

3 = <u>high</u> chance of dozing

	SITUATION	CHANCE OF DOZING
1.	Sitting and reading	_____
2.	Watching TV	_____
3.	Sitting, inactive in a public place (such as in a theater or meeting)	_____
4.	As a passenger in a car for an hour without a break	_____
5.	Lying down to rest in the afternoon when circumstances permit	_____
6.	Sitting and talking to someone	_____
7.	Sitting quietly after lunch without alcohol	_____
8.	In a car, while stopped for a few minutes in traffic	_____
	TOTAL	_____

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JOINT COMMISSION

ACCREDITED

REM Diagnostics, Inc.

Specialists in Sleep

Our goal at REM is to provide you with the highest quality in sleep diagnostics with the latest technology in a safe, comfortable environment. Our licensed technicians extend every effort to identify and treat sleep disorders and help you achieve a Great Night's Sleep!

Our highly trained staff of technicians uses state-of-the-art digital equipment and sophisticated software in the identification and treatment of sleep disorders. You will be greeted by our friendly staff upon your arrival and we will do everything possible to ensure you have a comfortable night's sleep.

The attractive furnishings, comfortable atmosphere and friendly personnel set us apart from other labs. Our commitment is to minimize any normal stress some people experience before undergoing medical testing. Our bedrooms are designed with your comfort in mind with a hotel-like atmosphere, comfortable, with queen-sized beds. Please feel free to bring your own pillow or book to read.

We strive to provide the comforts of home in our sleep lab. We want your experience to be positive; our staff will provide the highest level of care to make sure you achieve a restful night's sleep. Please do not hesitate to call with questions or concerns at (805)785-0126.

To prove our commitment to patient care and safety we are proud to be Joint Commission Accredited. Please feel free to log online to find out more information about our standard of care at www.jointcommission.org or 630-792-5800.

Sincerely,

Tim Plooy, RPSGT
Lab Manager
REM Diagnostics, Inc.

REM Diagnostics, Inc.

Joint Commission Accredited
Phone: (805) 785-0126

Fax: (805) 785-0127

www.remdiagnosticsinc.com

POLICY ON CONFIDENTIALITY

REM Diagnostics, Inc. will maintain all patient information and records in a manner to guarantee the confidentiality of all information.

Patient records and information will be stored electronically on computers utilizing access codes to guarantee that only authorized employees will have access. Information obtained will be for the sole purpose of performing sleep studies and in obtaining authorized reimbursement.

The medical record, reports, and data recordings will be sent to one of our sleep and/or pulmonary specialists authorized to review the information and provide a medical interpretation of sleep studies. The sleep and/or pulmonary specialist will maintain the confidentiality of the information. The medical interpretation of sleep studies is done via a secure, password-protected and encrypted web site. Current physicians providing interpretation include Ross Michel, M.D., Mark Soll, M.D., Laura Lubarsky, M.D., and Michael Ryan, M.D.

Patients may authorize the distribution of this information to another physician, clinic, hospital, or other entity responsible for the patient's health care via written authorization. This authorization will be retained in the patient's medical record.

All patient medical records will be retained for seven years. In the event that patient records have exceeded seven years, or if computer software and/or hardware is updated, all information stored will be destroyed in a manner to guaranteed that it is not retrievable.