TAMC SLEEP DISORDERS CENTER

PATIENT HOME SLEEP TESTING ASSESSMENT

Name ____ Sponsor SSN ______-_____-_________ Date _____________

Age ________ Date of Birth ____________ Male / Female (circle) Height ______in Weight _______lbs Neck ______in (tech measured)

Email ____ Best Phone # _______________________

BMI ______ (tech calculated)

Circle one: Retiree Family Member Veteran Active Duty

Have you had a Sleep Study? Yes No (circle) **If Yes**, when & results?_____________________________________

Do you have or are suspected to have any of the following: (please check) _____ BMI > 40

_____ Moderate to severe pulmonary disease
_____ Neuromuscular disease
_____ Congestive heart failure
_____ Narcolepsy

_____Trouble falling asleep _____Trouble staying asleep
_____ Sleepwalking or Night terrors
_____ Irregular sleep time, Shift work, Frequent jet lag
_____ Involuntary limb (ex. leg) movement during sleep

STOP - BANG questionnaire:

S (snore) - Have you been told that you snore? **Yes**____
T (tired) - Are you often tired during the day? **Yes**____
O (obstruction) - Do you know if you stop breathing or has anyone seen you stop breathing while asleep? **Yes**___
P (pressure) - Do you have high blood pressure or on medication to control high blood pressure? **Yes**____

STOP Score _______ (please add # of Yes's)
If you answered YES to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea.

B (BMI) - Is your body mass index greater than 35? **Yes**____
A (age) - Are you 50 years old or older? **Yes**____
N (neck) - Are you a male with a neck circumference greater that 17 inches, or a female with a neck circumference greater that 16 inches? **Yes**____
G (gender) - Are you a male? **Yes**____

BANG Score _______ (please add # of Yes's)
The more questions you answer YES to on the BANG portion, the greater risk of having moderate to severe OSA

Physician use only

____For patients who in-lab PSG is not possible by virtue of immobility, safety, or critical illness.
____HST test to check dental device or weight loss effectiveness.
____High probability of moderate to severe OSA on the clinical evaluation with no comorbidities despite negative stop bang questionnaire.

SLEEP PHYSICIAN USE ONLY

HST Candidate? ____Yes ____No

____ Apnealink Plus ____ NOX-T3

***If Yes** – Dispense HST device. Provide education and instructions.*
***If No** – Enter network referral for in-lab study or schedule study at TAMC.*

TRIPLER ARMY MEDICAL CENTER
DEPARTMENT OF MEDICINE
SLEEP DISORDERS CENTER

SLEEP HISTORY QUESTIONNAIRE

Name ______________________________________ Sponsor SSN ______-______-__________ Date ______________

Occupation____

Are you taking any sleep or pain medications? **If Yes,** please list below _______________________________________
____
____

Please describe what type of problems are you having with your sleep?
____
____

Have you had a sleeping problem diagnosed in the past? **Yes** **No** **If Yes,** what was the problem?
____
____

If Yes, what treatments were needed? ____

Did the treatments help? **Yes** **No** Which medical facility?________________________________When?____________
month/year

Are you currently on CPAP? **Yes** **No** If Yes, are you having any problems with your machine or mask? **Yes** **No**

If Yes, please describe:____

Excessive Sleepiness

Do you feel excessively sleepy in the daytime? **Yes** **No** **If Yes,** how long? ____________months / years (circle)

Do you feel your sleepiness is a result of poor quality of nighttime sleep? **Yes** **No**

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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:

0 = Would never dose **1** = Slight chance of dozing **2** = Moderate chance of dozing **3** = High chance of dozing

SITUATION	CHANCE OF DOZING (CIRCLE APPROPRIATE #)			
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
Sitting in a car as a passenger for a continuous hour……………………………………	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
Sitting in a car stopped in traffic for a few minutes………………………………………	0	1	2	3

Score: **0-10** Normal range **10-12** Borderline **12-24** Sleepy **Total: ______________________________**

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MEMORANDUM FOR RECORD

SUBJECT: SAFETY STATEMENT AND PRECAUTIONS

You are being evaluated for a sleep disorder. There may be a high likelihood that you have a sleeping disorder which may adversely affect your driving. People with sleep disorders have a three to four-fold increased risk of motor vehicle accidents due to sleepiness or lapses in attention. These accidents may cause serious injuries or death to you or others.

If you have had an accident or near-accidents due to sleepiness or inattentive driving, you should stop driving or operating dangerous machinery until your sleep disorder has been treated and you are no longer sleepy or inattentive while driving.

It is your responsibility not to drive or operate dangerous equipment if you are sleepy. If you drive or fly professionally, you must report your sleep condition to the physician who certifies you as fit for this profession.

Signing below acknowledges your understanding of the above statement.

Patient's Name (print) ________________________ Date: ______________

Signature _________________________________

Please go to http://drowsydriving.org/ for more information
about driving safety and preventing drowsy driving.

Standard Medical Information Release Agreement

In accordance with the Health Insurance Portability and Accountability Act, in some circumstances you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. These opportunities are outlined below:

1. MTF Directories

Unless you object, we will use and disclose in our MTF inpatient directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people who ask for you by name. Only members of the clergy will be told your religious affiliation.

If you object, we will not provide any of the above detailed information about you to anyone including family, friends, co-workers, delivery services (florist), etc who make an inquiry.

☐ **You may use my protected health information as described in paragraph 1 above.**

☐ **You may not use my protected health information as described in paragraph 1 above.**

____ __________________

PATIENT'S SIGNATURE **DATE**

2. Individuals Involved in Your Health Care

Unless you object, we may disclose to a member of you family, a relative, a close friend or any other person you identify, your protected health information to someone who helps pay for your care.

Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. Finally, we may use of disclose your protected health information to an authorized public or private entity to assist in disaster release efforts and coordinate uses and disclosure to family or other individual involved in your health care.

☐ **You may use my protected health information as described in paragraph 2 above.**

☐ **You may not use my protected health information as described in paragraph 2 above.**

____ __________________

PATIENT'S SIGNATURE **DATE**

Acknowledgment of Receipt
Military Health System
Notice of Privacy Practices

The **"Military Health System Notice of Privacy Practices"** pamphlet is available for your review in the group classroom and in the waiting room.

If you cannot find it, please ask us for a copy.

The signature below only acknowledges receipt of the Military Health System Notice of Privacy Practices, effective date <u>14 April 2003.</u>

____

Signature of Patient/Patient Representative   Date

____

Name of Patient/Representative (Print)   Relationship to Patient (If Applicable)

☐ *Patient/Representative Declined to Sign*   ______*MTF Staff Initials*

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/ beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED. This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record. Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

______________________________	____________________	__________
SIGNATURE OF PATIENT OR SPONSOR	**SSN OF MEMBER OR SPONSOR**	**DATE**

TRIPLER ARMY MEDICAL CENTER
DEPARTMENT OF MEDICINE
SLEEP DISORDERS CENTER

Healthy Sleep Habits

Sleep hygiene refers to "cleaning up" sleep habits that interfere with good sleep. These habits often develop in response to insomnia, but are counterproductive. Practicing good sleep habits is recommended for everyone that has a sleep disorder.

Go to http://www.sleepfoundation.org/article/sleep-topics/healthy-sleep-tips for healthy sleep tips and http://www.sleepfoundation.org/article/sleep-related-problems/obstructive-sleep-apnea-and-sleep for more information on sleep apnea.

1. **Sleep as much as needed to feel refreshed and healthy during the following day, but not more.** Curtailing time in bed a bit seems to solidify sleep; excessively long times in bed seem related to fragmented and shallow sleep.

2. **Maintain a consistent, regular routine.** Start by setting a routine time to wake up and get out of bed. Once your sleep improves, keep to a standard time to go to bed. This routine needs to be maintained every day of the week.

3. **Never try to sleep.** Only go to bed when you feel sleepy and do not try to force yourself to fall asleep. This will only tend to make you more awake and is counterproductive. If you wake up in the middle of the night, let yourself fall asleep within 15-20 minutes. If you cannot fall asleep, get out of bed and do something relaxing. When you are sleepy, return to bed and go to sleep.

4. **Use the bedroom only for sleep** and intimacy. Do not watch TV, eat, drink, read, have arguments or discussions while in bed. These tend to keep you awake.

5. **Avoid napping** unless absolutely required. Particularly avoid routine, daily naps. Napping interferes with the ability to fall asleep at night. If you need to nap for safety reasons (driving, etc) then a short 30-60 minute nap is okay.

6. **Avoid coffee, alcohol, and nicotine.** Caffeine will tend to keep you awake. The effects of caffeine on sleep usually takes several hours to go away, however in some people the effects are prolonged. Alcohol may make some people fall asleep more quickly (but not everyone), however alcohol leads to fragmented sleep and does not provide good restful sleep. Nicotine is a stimulant and tends to reduce the quality of sleep, and nicotine withdrawal at night tends to do the same. Quitting smoking is recommended for all smokers for many reasons.

7. **Exercise in the late afternoon or early evening** can improve sleep. Do not exercise within several hours of attempting to go to sleep – this will keep you awake. Gentle stretching for relaxation can help you fall asleep.

8. **Ensure you are sleeping in a quiet, dark, comfortable environment.**

9. **A light bedtime snack (especially warm milk or similar drink) seems to help many individuals sleep.** Hunger may disturb sleep.

10. **Move the bedroom clock to where you cannot see it.** Some recommend removing the clock from the bedroom entirely. Looking at the clock will keep you awake; it does not help you fall asleep.

Please Keep This Page For Your Reference & SLEEP WELL !