McAlester Regional
HEALTH CENTER
Southeast Oklahoma's Leading Healthcare Resource

CONSENT FOR HOME SLEEP TEST

DATE: _____

ORDERING PHYSICIAN: _____

TECHNOLOGIST: _____

DEVICE # _____/_____

Your doctor has ordered a Home Sleep Test (HST) to evaluate your breathing during sleep.
HST is used to diagnose Obstructive Sleep Apnea (OSA), a potentially life-threatening medical disorder that occurs when the muscles of the throat relax during sleep causing the airway to collapse; which prevents the person from breathing normally.

Your HST will be conducted using a device called WatchPAT. The WatchPAT consists of a wrist-strap, monitoring device, integrated finger probe, and a snore/body position sensor.

It is important to not allow the WatchPAT to become wet, so please do not shower, bathe, or wash your hands while wearing the WatchPAT.

Be sure to allow yourself a minimum of 6-hours of time in bed to sleep while wearing the WatchPAT.

If you have any problems with your WatchPAT during the night, or notice an Error Code, please write down the Error Code, and then call 1-888-748-2627.

Once you have finished sleeping, and are ready to begin your day, remove the WatchPAT from your body, place it in the bag provided to you, and return it to the hospital before 7:00 P.M. that day.

The results of your Home Sleep Test will be sent directly to your Doctor within 10 days. Please contact your Doctor to obtain your Home Sleep Test results.

I understand that I may be financially responsible for failure to return the WatchPAT device to the hospital as instructed in the Consent Form, or for damage to the WatchPAT.

I understand these instructions; any questions I had were adequately answered for me by the Technologist, and I will return the WatchPAT on: _____.

_____ _____

Patient Signature Date & Time

PATIENT LABEL

McAlester Regional HEALTH CENTER
Southeast Oklahoma's Leading Healthcare Resource

MR11001

PATIENT LABEL

CONDITIONS ON ADMISSION

Please read carefully. In order to prevent misunderstanding, the hospital requires the following to be signed for all admissions:

GENERAL CONSENT FOR HOSPITAL CARE: I consent to hospital care encompassing diagnostic procedures and medical treatment. If I am an obstetrical patient admitted to the hospital for the delivery of my baby, I also consent to hospital care of my infant(s) encompassing diagnostic procedures and medical treatment.

I hereby authorize the physician or physicians in charge of my care to administer any treatment and perform such technical procedures as may be deemed necessary or advisable in the diagnosis and treatment of my illness. I understand that with the exception of physicians employed by the hospital, the physicians on staff at McAlester Regional, such as radiologists, anesthesiologists and pathologists, are not employees or agents of the hospital but are independent contractors who have been granted privileges to use the hospital facilities.

USE OF STUDENTS / INTERNS: Please be advised that the Health Center has students in clinical training on the facility's premises. Clinical areas include, but are not limited to, medical students, nursing students, radiological technician students and physician assistant students. All students practice under the guidance of a hospital or medical staff member.

DISCLOSURE OF INFORMATION: I understand that my medical records and billing information are made and retained by McAlester Regional Health Center and are accessible to hospital personnel and medical staff. Hospital personnel and physicians in attendance may use and disclose medical information for hospital operations and functions and to any other physician or health care provider involved in my continuum of care for this admission. Safeguards are in place to discourage improper access. MRHC and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-care. Oklahoma law requires that we advise you that **the information authorized for disclosure may include information which maybe considered a communicable or venereal disease, including but not limited to, hepatitis, syphilis, gonorrhea, human immunodeficiency virus and acquired immune deficiency syndrome (AIDS).**

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: For services rendered to me, I assign and authorize payment to McAlester Regional Health Center, of any hospital benefits including Major Medical Benefits. Physician benefits otherwise payable to the insured are to be made payable to the physician(s) responsible for my care. I understand that I am responsible for and guarantee payment of any health insurance deductibles and co-pays, denied charges, and ineligible benefits. I fully understand that this bill is subject to any charges and/or credits not available at dismissal, as well as changes in the estimated insurance benefits fees and court costs related to collection of this account.

THIRD PARTY LIABILITY AND BILLING: If this hospitalization is for treatment of an injury, illness or condition which may have been caused by a third party, for which that third party is, or may be liable for damages, I agree to give MRHC a lien, up to the amount of the outstanding charges of MRHC for the care provided, on any recovery I make from the third party, the third party's insurance company, the third party's employer, the third party's guarantor or third party's principal, or form my own uninsured or underinsured motorist coverage or that of my spouse, my parents (if a minor), or my guardian. Further I authorize MRHC and its associates or agents to initiate claims for services provided to me, including but not limited to insurance claims where I am named the insured. I further agree that if there is no third party recovery or recovery from underinsured motorist coverage, I am still personally responsible for payment of the outstanding charges.

RELEASE FROM LOST VALUABLES: I understand and agree that Health Center maintains a safe for the keeping of money and other valuable and that the **Health Center shall not be liable for loss of damage of any personal property,** unless deposited with the Health Center for safe keeping.

I certify that the above statements are true and correct to the best of my knowledge and that I am the patient or am duly authorized by the patient to execute the above agreement and accent its terms.

PATIENT, GUARDIAN OR AUTHORIZED PERSON TO SIGN FOR PATIENT

WITNESS DATE TIME

REASON IF PATIENT IS UNABLE TO SIGN:
- ☐ **Minor (under 18 years)**
- ☐ **Physical condition**
- ☐ **Mental condition**

RELATION TO PATIENT

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS:
REQUIRED BY LAW.

A complete description of how your medical information will be used and disclosed by this facility is in our NOTICE OF PRIVACY PRACTICES. By signing below, you acknowledge that you have been given a copy of this Notice and Patient Rights as required by law.

PATIENT, guardian or authorized person to sign for patient | Date/Time | Witness

McAlester Regional Health Center Sleep Laboratory
Patient Sleep History

1 Clark Bass Blvd
McAlester, OK 74501
Tel: 918-421-8097 Fax: 918-421-6827

Confidential Record: Information contained herein will not be released unless you have authorized us to do so.

Last Name First Name Middle Name

Birth Date Sex M F Age Height Weight Martial Status

Home Phone: _____ Business Phone: _____

Employer Occupation

- Please describe your sleep problem(s). Please be as specific as possible.

  (For example, "*my bed partner can't sleep because of my snoring"; I sometimes fall asleep unintentionally; I stop breathing in my sleep; I have trouble falling asleep: I am sleepy most of the time; My legs jerk all through the night: I often awaken with heartburn or choking on stomach acid: etc.)*

- When did your sleep problem (s) begin?

Typical Sleep Habits

- What time do you usually go to bed? _____
- What time do you usually get up? _____
- How many hours do you sleep in a typical night? _____
- When you awaken in the morning do you usually feel refreshed? YES NO
  If NO, please describe how you feel._____

  _____

  _____

- When your schedule allows you to sleep as late in the morning as you wish, *how many hours* will you sleep?_____
- Do you nap during the day or in the evening before going to bed? YES NO
- Do you work a night shift or a rotating shift? YES NO
  If YES, please explain. _____

  _____

  _____

Daytime Sleepiness

- Do you feel that you are sleepier during the day than you should be? YES NO
- If YES, at what age did you begin to experience excessive sleepiness? _____
- Do you sometimes doze or fall asleep unintentionally? YES NO

Please rate on a scale of zero to three the chances of dozing in these circumstances.
0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Sitting and reading 0 1 2 3

Watching Television 0 1 2 3

Sitting inactive in a public place, like a theater or movie 0 1 2 3

As a passenger in a car for an hour without a break 0 1 2 3

Lying down to rest in the afternoon 0 1 2 3

Sitting and talking to someone 0 1 2 3

Sitting quietly after lunch (when you've had no alcohol) 0 1 2 3

In a car; while stopped in traffic or driving 0 1 2 3

Ability to Fall Asleep and Maintain Sleep

- Do you often have trouble falling asleep? YES NO
  If YES, how long does it typically take you to fall asleep after the lights are turned off? _____

- Do you wake up during the night? YES NO

- How many times do you awaken during a typical night? _____
  Following these awakenings, do you fall back to sleep easily? YES NO

- Do you sometimes wake up several hours early and find that you are unable to sleep the remainder of the night? YES NO
  If YES, does this happen often enough to be considered a problem? YES NO

  Are pain control issues interrupting your sleep? YES NO

  If yes, what pain issues are disturbing your sleep? _____

Breathing and Sleep

- Have you been told that you snore? YES NO
  If YES:
  How old were you when you first began to snore? _____

  Rate the loudness of your snoring by circling one of the numbers below.

Very Soft Very Loud

1 2 3 4 5 6 7 8 9 10

  Do you snore if you sleep on your side? YES NO DON'T KNOW

- Have you been told that you stop breathing or have pauses in your breathing during sleep? YES NO
  If YES, when was this first noticed? _____

- Do you awake suddenly feeling short of breath? YES NO
  If YES, how often does this happen? _____

- Do you have trouble breathing through your nose? ALWAYS FREQUENTLY RARELY

- Please provide any additional details about your breathing during sleep that you think may be important.

  _____
  _____
  _____
  _____

REM Intrusion Symptoms

* Do you sometimes experience dreams just as you are falling asleep? YES NO

* When you are falling asleep do you ever see vivid, life-like images? YES NO

* Have you ever experienced sudden muscle weakness (not dizziness, not fainting) which made it difficult to stand or difficult to maintain control of your head or arms and hands? YES NO

If yes, was this sudden weakness associated with any particular type of event or emotional state? (examples: laughing vigorously, anger, fear during a frightening event.) YES NO

If yes, please describe the situations that led to these episodes of sudden weakness:

_____
_____
_____
_____

* Have you ever experienced an occasion during which you awoke fully, but found it impossible to move for a minute or so? YES NO
If yes, how often does this happen?_____

* Have you ever felt paralyzed as you were falling asleep? YES NO
If yes, how often does this happen?_____

General Sleep Symptoms

* Do you awaken with headaches that seem to fade away after a few minutes to an hour or so? YES NO
If yes, how often do these headaches occur?_____

* Do you sweat in your sleep, even when the room is cool? YES NO
If yes, how often ?_____

* Do you ever experience a strong sensation of discomfort in your legs when you relax or when you lie down to sleep? YES NO
If yes, describe this sensation: (e.g., cramps, a restless sensation requiring movement, etc.
_____

* Have you been told that you kick or move your legs repeatedly during your sleep? YES NO
If yes, how often do you do this?_____

* Do you frequently awaken with hoarseness? YES NO

* Do you frequently awaken with sore throat? YES NO

* Do you awaken with indigestion/heartburn? YES NO
If yes, how often does this happen? (e.g., twice a week)_____

* Do you awaken with a sour, acidic stomach fluid or vomit in your mouth? YES NO
If yes, how often does this happen? (e.g., almost every night)_____
* Do you take antacids or other medicine for acid stomach, indigestion, or heartburn that bothers you during your sleep? YES NO

If yes, do the medicines you take for acid stomach, indigestion, or heartburn during sleep prevent these problems from occurring?

COMPLETELY USUALLY SOMETIMES ALMOST NEVER

OTHER

* How many cups of coffee and glasses of tea do you drink in a typical day?_____
* If you drink alcoholic beverages, how many of the following do you drink in a typical day:
  - Bottles/cans of Beer?_____
  - Glasses of Wine?_____
  - Ounces of Whiskey?_____

Surgical History

Have you had any of the following surgeries:

Tonsillectomy	NO	YES	Approx Date_____
Nasal Surgery (e.g., septoplasty)	NO	YES	Approx Date_____
Heart Surgery (e.g., bypass)	NO	YES	Approx Date_____
Coronary Angiogram/angioplasty	NO	YES	Approx Date_____
Pacemaker implantation	NO	YES	Approx Date_____
Uvulopalatopharyngoplasty (UPPP)	NO	YES	Approx Date_____
Laser-assisted uvulopalatoplasty (LAUP)	NO	YES	Approx Date_____
Women only: Hysterectomy	NO	YES	Approx Date_____

Please list any other surgical procedures and give approximate dates:

_____
_____
_____
_____
_____

Health Problems

* Has a physician told you that you have or had any of the following:

High blood pressure	YES	NO
Irregular heartbeat	YES	NO
Angina	YES	NO
Heart attack	YES	NO
Emphysema	YES	NO
Congestive Heart Failure	YES	NO
Diabetes	YES	NO
Asthma	YES	NO
Low Thyroid	YES	NO
Low potassium	YES	NO
Low Calcium	YES	NO
Polio	YES	NO

Please list any other current health problems:

_____
_____
_____
_____
_____
_____

Medications

* Please list all current prescriptions and over the counter medications

Name of Medication	Amount (Dosage)	How often taken	For what problem do you take this medicine?

Prior Sleep Studies, Prior Treatment of Sleep Disorders

* Have you had a previous sleep study? YES NO
  If yes, when was the study done? Month_____ Year_____
  If yes, where was the study done?_____
  If yes, what was the diagnosis? (example "Sleep Apnea and Restless Legs Syndrome)_____
  _____

* Have you ever been treated for a sleep disorder? YES NO
  If yes, please describe the treatment you received. (example "Put of CPAP at 12 cm pressure)
_____
_____

* Do you have an additional comments that might be helpful to us in understanding your sleep problem?_____
_____
_____
_____

Thank you for helping us better understand your sleep issues.

MRHC

Post-Sleep Questionnaire

Patient Name: _____ Date of Study: _____

Type of Study: _____ Technician: _____

01. How long did it take you to fall asleep? _____Hrs. _____Mins.

02. How does this sleep latency compare to your normal sleep at home? Longer Shorter Average

03. In your opinion, how much sleep do you feel you obtained last night? _____Hrs. _____Mins.

04. How does the length of sleep last night compare to at home? Longer Shorter Average

05. Mark on the scale below how you rate the quality of your sleep last night?

0 1 2 3 4 5 6 7 8 9 10
Poor **Average** **Deep**

06. How many times did you wake up last night? _____

07. In your opinion, what woke you up? _____

a. Did you wake up short of breath or smothering last night? ___ Yes ___ No

b. Did you wake up sweating? ___ Yes ___ No

c. Did you wake up with chest pain or heart palpitations? ___ Yes ___ No

d. Did you have difficulty returning to sleep? ___ Yes ___ No

e. Did you awaken in a state of panic or confusion? ___ Yes ___ No

08. Mark on the scale below how rested you feel this morning?

0 1 2 3 4 5 6 7 8 9 10
Very Sleepy **Still Sleepy** **Average** **Rested** **Wide Awake**

09. How does your sleep last night compare to your normal sleep at home? ___ Much Worse ___ Worse ___ Average ___ Better ___ Much Better

10. Describe below any pertinent information or comments regarding your sleep evaluations:

_____

_____

If last night's evaluation was performed utilizing nasal CPAP or Bi-Level Therapy, please complete the following:

01. Did you tolerate the use of nasal CPAP therapy during your evaluation last night? ___ Yes ___ No

02. Will you comply with nasal CPAP if your physician prescribes this therapy for you? ___ Yes ___ No

03. Evaluate your sleep using nasal CPAP as it compares to your normal sleep at home: ___ Much Worse ___ Worse ___ Average ___ Improved ___ Much Improved

04. Did you experience any degree of claustrophobia while using nasal CPAP? ___ Yes ___ No

05. Did you experience any nasal congestion or dryness while using nasal CPAP? ___ Yes ___ No

06. Did you experience any discomfort with the mask utilized with nasal CPAP? ___ Yes ___ No

Your comments regarding nasal CPAP therapy: _____

MRHC

Pre-Sleep Questionnaire

PERTINENT INFORMATION:

Patient Name: _____ Date of Study: _____

PRE-SLEEP QUESTIONNAIRE:

01. What time did you go to sleep last night? _____

02. What time did you wake and begin your daily activities today? _____

03. How much sleep did you obtain last night? _____

04. Did you nap during the day? ____ Yes ____ No

If yes, how many naps did you take today? _____

05. Was today any more physically strenuous than usual? ____ Yes ____ No

06. Was today any more emotionally demanding than usual? ____ Yes ____ No

If yes, are you anxious or emotionally upset? ____ Yes ____ No

07. Are you acutely ill at present? ____ Yes ____ No

If yes, please describe: _____

_____

08. What time did you eat last? _____

09. Have you had any caffeinated beverages today? ____ Yes ____ No

10. What medications do you take prior to bedtime? (please list)

_____

_____

11. Mark on the scale below how sleepy you feel at present:

0	1	2	3	4	5	6	7	8	9	10
Very Sleepy		**Still Sleepy**			**Average**		**Rested**			**Wide Awake**