



Utah Sleep & Pulmonary Specialists
9103 South 1300 West, Suite 103
(801) 432-8690

_____ is scheduled for a _____
On _____ at _____.

Your sleep study is scheduled for the date and time indicated above. Please arrive at the scheduled time. The technician arrives only 15 minutes before you. If you have any questions, please call (801) 432-8690. You must notify Utah Sleep and Pulmonary Specialists at least 24 hours in advance should you need to change your appointment or you will be charged \$50. Failure to show up for your test will also result in a \$50 charge. **PLEASE BRING YOUR INSURANCE CARD.**

Patient signature (responsible party): _____

Date: _____

Additional Instructions

- Please have your child come freshly showered with clean, dry hair. Avoid using creams or lotions on your body. This will allow the equipment placed on you to conduct a clearer signal and will expedite the analysis process of the study.
- Fill out the enclosed questionnaires and Patient Information form. Please bring ALL of the paperwork, along with insurance verification if we have not already received this from you to your appointment. Some of the paperwork may seem redundant; however it is important to bring it with you filled out to your sleep study.
- You are encouraged to bring any items that will help your child feel more comfortable such as: pajamas (loose fitting 2-piece under and outer wear, robe and slippers are recommended) favorite pillow, stuffed animal, book to read. However, please leave all valuables at home. You should bring any prescribed medications with you, or take them before arriving at the clinic
- Alert the technician if a specific wake-up time is needed. Otherwise you may be awakened at 5:00 AM or earlier



Utah Sleep & Pulmonary Specialists

Sleep Studies - What to Expect

- Please come freshly showered with clean, dry hair. Avoid using creams or lotions.
- Upon arrival at the sleep center you will be greeted by a sleep technician. The technician will verify your information, collect your paperwork and show you to your room.
- You will be given some time to change into your sleeping attire and make yourself comfortable. When you are ready, call the technician and they will begin the process of preparing you for the study.
- Please let us know if you have ANY additional needs or limitations (physical, social, etc.)
- An overnight sleep study for sleep apnea or other sleep disorder consists of attaching sensors to the body to measure chest and abdomen respiration, heart activity body movement, sleep stage, muscle activity, oxygen saturation, airflow and more. This includes cleaning the skin and taping sensors to the face, scalp, chin, chest and legs. The test is essentially painless but some discomfort may be experienced while the electrodes are being applied or removed.
- After the sensors are attached you may need to perform some breathing exercises. The technician will also have you move different parts of your body at various times to check the monitoring system.
- Although the technician may not administer medication of any kind, you **SHOULD CONTINUE** to take any medication prescribed by your doctor unless told otherwise.
- While sleeping in one of our sleep rooms at the center, a technician will monitor you from a nearby room. If you need to use the restroom during the night, please notify the technician. Please contact the technician if you need assistance of any kind. Snacks, juice and coffee are available in the morning after your test.
- Alert the technician if a specific wake-up time is needed.
- In the morning the technician will awaken you and unhook you from the monitoring equipment. You will then be asked to complete some additional paperwork including a morning questionnaire and satisfaction survey.
- Results of the study will be sent to your referring physician. The technician cannot provide any diagnostic information, interpret your symptoms or evaluate the outcome of your study.

IF YOU HAVE QUESTIONS PLEASE CALL (801) 432-8690



PATIENT NAME: _____
(Please print name)



HIPAA – Notice of Privacy Practices Acknowledgement

I acknowledge that I have had an opportunity to read, take a copy and make changes in writing of the Provider’s “Notice of Privacy Practices” (HIPAA Notice). This is available in the office or online (www.utsleep.com) and explains when, where, and why my confidential health information may be used or shared. Dr. Gregory Dupont, Dr. Kathleen Pfeffer and their staff may use and share my confidential health information with others only as needed for treatment, payment of my bill or for healthcare operations (such as tests ordering or communicating with my doctor(s), unless otherwise specified.

Signature of patient/person authorized to consent

Date

Please share my medical information with the following people:

Name

Relationship

Name

Relationship

Signature of patient/person authorized to consent

Date

A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:

- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe below):

Signature of Employee Completing Form: _____

Date Signed: _____



Patient Name: _____

(Please Print)

POLYSOMNOGRAPHY/EGG INFORMED CONSENT

Please read the following information to familiarize yourself with the type of test you will be having as a patient in the Utah Sleep & Pulmonary Specialists Clinic.

The Polysomnography test for sleep apnea or other sleep disorders consists of attaching sensors to the body to measure chest and abdomen respiration, heart activity, body movement, sleep stage, muscle activity, oxygen saturation, airflow and more. This includes cleaning the skin and taping sensors to the body which may cause a slight skin irritation in some people. Sensors will be taped to the face, scalp, chin, chest, and legs. The test is essentially painless but you will be asked to keep your eyes closed when the electrodes are being applied to or removed from your face. You will have cables on your body connecting the sensors to the monitoring equipment.

In addition you may perform some breathing exercises. These will include holding your breath while you are pushing your stomach in and out. This exercise may need to be repeated several times. The technician will also have you move different parts of your body at the beginning of the test.

The EEG sleep test (some patients do this part only) involves sensors applied to the scalp. This test is done to look for evidence of seizures while you sleep and may not involve any other monitoring.

Although the technician may not administer medication of any kind, you should continue to take any medication prescribed by your doctor unless told otherwise. The technician is trained to perform the specific test which has been ordered by your doctor and cannot provide any diagnostic information, interpret your symptoms or evaluate the outcome of your study. This is only one test providing specific information which will be added to your medical file. You will be receiving a bill for the sleep/EEG test, and you will receive a separate bill from the physician for the medical interpretation of the test.

A technician will monitor you from a nearby room. Please contact the technician if you need assistance of any kind. Other services, such as nursing assistance, are not provided. Snacks, juice and coffee are available in the morning after your test.

I have read and understand this and my questions have been answered to my satisfactorily.

Signature of Patient

Date

Signature/Relationship to Patient

Date

Reason for patient's inability to sign: _____

Signature of Witness

Date



NAME: _____
Last First

TODAY'S DATE: ___/___/___ BIRTHDATE: ___/___/___
Age

SEX: M F _____
Height Weight Neck Size

REFERRING DOCTOR: _____
Last First

Sleep Questionnaire

Utah Sleep & Pulmonary
Specialists

BEDTIME QUESTIONNAIRE

(Complete *before* test begins)

- Has today been unusual in any respect? Y N If yes, why? _____
- How much sleep did you have last night? _____ hours. Was this adequate? Y N
- Did you nap today? Y N If yes, at what time? _____ How long did you sleep? _____
- On the table below, list all medications you usually take. Include vitamins, aspirin, etc.

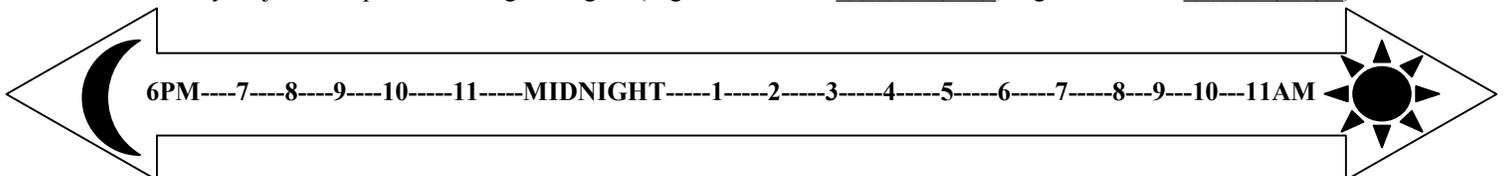
NAME OF USUAL MEDICATION <small>(PLEASE PRINT THIS INFORMATION CAREFULLY, TAKING NAMES AND SPELLING DIRECTLY FROM THE CONTAINERS.)</small>	USUAL AMOUNT	TONIGHT BEFORE TEST (circle one)		DURING THE TEST? (circle one)	
		Y	N	Y	N
		Y	N	Y	N
		Y	N	Y	N
		Y	N	Y	N
		Y	N	Y	N
		Y	N	Y	N
		Y	N	Y	N
		Y	N	Y	N
		Y	N	Y	N
		Y	N	Y	N
		Y	N	Y	N

- Any drug allergies? ___ No. If yes, please list: _____
- Please list any physical complaints you have now, or additional information: _____

MORNING QUESTIONNAIRE

(Complete *after* the test ends)

- Did you sleep with oxygen? Y N If yes, how much? _____ liters/min.
- Did you sleep with nasal CPAP? Y N If yes, how much? _____ cmH2O.
- How long did it take you to fall asleep last night after the lights were turned out? _____ hours and _____ minutes.
- How does this compare with the time it usually takes you to fall asleep?
much longer longer same shorter much shorter
- How long did you feel you slept last night? _____ hours and _____ minutes.
- How does this compare with the length of time you usually sleep?
much longer longer same shorter much shorter
- How many times do you remember waking up last night? _____ times.
- How do you feel right now compared with your usual feeling in the morning? _____
- Do you have any physical complaints this morning? Y N If yes, what? _____
- What awakened you this morning? noise technician discomfort spontaneous other _____
- In general how would you say your sleep last night compared with your usual sleep? _____
- Shade in the hours you think that you were asleep while being monitored and, in this way, indicate the approximate time and duration any major wake periods during the night. (Lights OUT time: _____; Lights ON time: _____).





Patient Satisfaction Survey

Utah Sleep & Pulmonary Specialists
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In order for the Sleep Disorders Clinic to more adequately meet your needs and continually improve our service to patients, would you please take a few minutes and provide us with some helpful information? **Please enclose and seal in the attached envelope.** Your comments will be viewed by a manager.

Study Date: ____/____/____

- OXIMETRY (finger sensor only)
- POLYSOMNOGRAPHY (full study)
- CPAP (with mask)
- BIPAP (with mask)
- OTHER _____

1. Did you experience any difficulties in scheduling your sleep test?
 Yes No Comments: _____
2. Any problem with parking or getting into the building?
 Yes No Comments: _____
3. Was the technician there to greet you when you arrived?
 Yes No Technician's name, if you remember: _____
4. How long did you wait after your scheduled appointment time until the technician began preparing you for the test?
5. Did the technician adequately explain the procedure? Yes No
Were your questions answered to your satisfaction? Yes No
6. Did the technician make you feel comfortable and at ease? Yes No
Was any aspect of your visit especially uncomfortable? Yes No
Comments: _____
7. Did the technician seem to be knowledgeable about the procedures he or she was performing? Yes No
8. Overall, how would you rate your visit to the Sleep Clinic?
 Very Good or Excellent
 Good
 Average (Not good or bad)
 Below Average
 Poor
9. What improvements could be made to serve you better?
10. Other comments:

Thank you for your time and effort in completing this information.

Sincerely,

Dr. Dupont and Dr. Pfeffer
Utah Sleep & Pulmonary Specialists

UTAH SLEEP & PULMONARY SPECIALISTS
9103 SOUTH 1300 WEST
SUITE 103
WEST JORDAN, UT 84088

From I-15 take the 9000 south exit and head west until you reach the light at 1300 west and then turn left (south). It will be on your left (the east side of the street) with Jordan Valley Dental on the corner. We are in suite 103 which is in the middle of the office strip.

