1138a South Road
Clovelly Park, SA 5042
Phone: 8373 4430 Fax: 8177 0689
Email: info@southernsleep.com.au
Business Hours Mon– Fri 9 am –5 pm

Thank you for choosing Southern Sleep's diagnostic services
Your Portable Diagnostic Sleep Study device set up as been booked on:

Time: _____ Date: _____

You will need to arrive at : **Southern Sleep**
1138a South Road
Clovelly Park SA 5042

You will be contacted separately by the outpatient clinics to notify you of your follow-up specialist appointment and receive your sleep study results, unless alternative arrangements are made with your specialist

IMPORTANT INFORMATION

Please read the following information prior to your sleep study

The following forms **must** be completed and brought with you on the night of the study.:
Confidential Patient Questionaire and the Epworth Sleepiness Scale

Things you need to do before you arrive for your sleep study set up:

Make sure you have had a shower before arrival for the sleep study set-up. Remove any moisturisers or makeup you may have on your face. Arrive in loose fitting clothing that you will be comfortable sleeping in (such as a T-shirt and track pants – see page 3) If you usually shave, please remove any stubble you may have. Please remove all nail polish from index fingers.

Payment

Payment can be made by EFT/Credit card or cash on the night of the study
Fees: $150 Private Fee $ 80 Pension / Concession / Private Fee

The morning after the study

The technician will instruct you on how to remove all of the equipment yourself, for when you wake up the next morning.

Sleep Monitor Units

Our monitors are booked to be used with other patients. To ensure we continue to maintain patient appointments as scheduled a late fee of $50.00 will be applied if monitors are returned after 10 am on the morning following your set up appointment – unless prior arranngements have been made with our office staff. **To avoid attracting the late fee, the equipment** (along with the patient feedback form) **MUST to be returned by 10 am the next morning to the same location, 1138a South Road, Clovelly Park, SA 5042. Failure to return the equipment the following morning could attract fees.**

Patient Account Payment Responsibility

Please be advised that out-of-pocket expenses may be incurred. It is Southern Sleep policy that full payment of your account is required on the day of service. For services covered by Medicare on online claim will be lodged. Eligible rebates will be paid directly into your bank account, providing this is registered by Medicare. For services not covered by Medicare, full payment on the day of service is required. A collection fee may be charged for overdue accounts.

If you cannot attend your appointment, please notify us within 48 hours of your scheduled time. Please call **8373 4430** or email us at **info@southernsleep.com.au** as soon as possible to cancel or re-book! Our sleep technitians only attent to confirmed appointments. *Fees may apply for cancellations within24 hours of your scheduled appointment.

Patient Name:_____
Signature: _____
Date: _____

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Epworth Sleepiness Scale

(Subjective measure of sleepiness)

Name: _____ Age (years): _____

Today's Date: _____ Gender (tick): Male ☐ Female ☐

How likely are you to 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:

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

Situation	**Chance of dozing**
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place (eg theatre or a meeting)	____
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 lunch without alcohol	____
In a car, while stopped for a few minutes in the traffic	____
Total score:	_____

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Confidential Patient Questionnaire

NAME: .....

DATE OF BIRTH: .....

GENDER: .....

REFERRING DOCTOR: .....

The following information is requested to assist us in giving you the best possible care. All of the information you provide will be treated as strictly confidential.

Try as best you can to answer all questions. If you are certain that a question does not apply to you leave it blank.

Section 1

Listed below are some screening questions that will help inform our sleep physicians about your risk factors for obstructive sleep apnoea. Please answer each question with either yes/no or by filling out in space provided.

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? Yes / No
2. Do you often feel tired, fatigued, or sleepy during daytime? Yes / No
3. Has anyone observed you stop breathing during your sleep? Yes/ No
4. Do you have or are you being treated for high blood pressure? Yes / No
5. *What is your current height …….. cm and weight? …… kg*
7. Please measure your neck circumference and write it in space provided …….. Cm

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Section 2

Listed below are hypothetical statements about night and daytime symptoms. Please circle an answer from 1 to 5 that is *most* true for *your situation* using the following scale:

1 = NEVER
2 = RARELY
3 = SOMETIMES
4 = OFTEN
5 = ALWAYS
N/A = Not applicable

1	My **nose blocks** up when trying to sleep (allergies, infections).	1 2 3 4 5
2	I wake with a **dry mouth.**	1 2 3 4 5
3	I wake in the morning with a **headache.**	1 2 3 4 5
4	I have daytime naps. (Average number per day = ...)	1 2 3 4 5
5	I suffer from impairment of **memory.**	1 2 3 4 5
6	I find it difficult to **concentrate.**	1 2 3 4 5
7	I experience **restless legs,** which stop me from falling asleep.	1 2 3 4 5
8	I experience or I am told that I **sleep walk**.	1 2 3 4 5
9	My sleep is disturbed by pain in the neck, back, muscles/joints/ legs/arms/chest?	1 2 3 4 5

Section 3

This section asks a number of questions related to your typical sleep habits. Please provide an answer on the dotted line.

1. At what time do you usually go to bed on weeknights? .....
2. At what time do you usually go to bed on weekend nights? .....

3. How many night per week do you take something to help you get to sleep? .....

Please specify what you take .....
Pleas specify the amount you take .....

4. Do you feel that you typically get enough sleep during the night? .....

5. How many times do you estimate that you wake up during the night? .....

6. Do you work rotating shifts or unusual times? .....

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Section 4

This section asks questions about some medical and lifestyle factors.

1	Do you **smoke** cigarettes? (Average daily number = ...)	Yes	No
2	If you do not smoke now, have you smoked in the past? (Average daily number =.....)	Yes	No
3	Do you drink **alcohol**? (Average amount = ...)	Yes	No
4	Is your sleep disturbed by pain in the neck, back, muscles/joints/legs/ arms/chest?	Yes	No
5	Do you have any known medical issues related to your breathing or heart? Please specify		

PREVIOUS SLEEP STUDIES:

Please name any other Sleep Centre you have attended and specify any treatment you have received for a sleep problem.

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Signed by:

Printed Name: .....

Signature: .....

Date: .....