

194 West St.
Westview Plaza, Suite 10
Milford, MA 01757
Phone: 508-381-6590
FAX: 508-381-6593



SLEEP STUDY

Your doctor has requested a sleep study for you. The study may be a “Home Sleep Apnea Test” or an attended overnight Sleep Study (Polysomnography); with or without treatment.

All tests will be performed or set up at the Tri-County Sleep Center at 194 West St.; Suite 10, Milford, MA, 01757. Home testing set ups take generally less than 1 hour, and overnight studies run from 8:30pm until 6-7:00am.

The sleep center will call you to book your study once the details of the order are verified and your medical insurance has provided prior authorization if required. This generally takes a few days.

Feel free to call us if you have any questions. Thanks!

VISIT US AT:

www.tricountymedical.org (Practices/Tri-County Sleep Center)



SLEEP QUESTIONS

NAME: _____

DATE: _____ HEIGHT: _____ WEIGHT: _____
 Has your weight changed in the past 5 years? YES NO Gained ___ lbs Lost ___ lbs
 Do you snore or do people tell you that you snore? YES NO _____
 If so, for how long? _____
 Has anyone told you that you stop breathing while asleep? YES NO
 When you wake up in the morning do you feel un- refreshed? YES NO
 How long have you felt extra sleepy during the day? _____
 Do you frequently awaken with a headache? YES NO
 How many automobile accidents have you been involved in the past 5 years? _____
 What time do you usually go to bed? _____ AM PM Wake up at: _____ AM PM
 On a typical night at bedtime, do you leave on TV ___ Music ___ Light ___ Other _____
 Comment: _____

Do you have: Difficulty falling asleep? YES NO Difficulty staying asleep? YES NO
 Does anything frequently awaken you at night? HEARTBURN ___ PAIN ___
 GO TO BATHROOM ___ BREATHING ___ OTHER _____

Do you have an urge to move your legs or an uncomfortable feeling in your legs?
 YES NO

If so: Does this urge increase when you are inactive? YES NO
 Does this urge decrease or go away when you walk or stretch? YES NO
 Is this urge or discomfort worse in the evening/night? YES NO

Please 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 (0-3)

Sitting and reading	
Watching television	
Sitting inactive in a public place at a theater or meeting	
As a passenger in a car for 1 hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (when you have had no alcohol)	
In a car while stopped in traffic	
TOTAL	

MEDICAL DATA AND INFORMATION

TRI-COUNTY SLEEP CENTER

A Tri-County Medical Associates Facility
The Benchmark for Quality Care

**A member of the Milford Regional
 Healthcare System**

NAME: _____ AGE: _____ BIRTHDATE: _____

SEX: MALE FEMALE

Do you have any problem caring for yourself at home? YES NO

Do you need someone to assist caring for you at night? YES NO

Do you use a wheelchair or a walker? YES NO

Do you need an electric hospital style bed or shower? YES NO

Do you have the following: Scalp/skin sensitivities _____ Wig or hairpiece _____

Operations and Surgery: Please indicate if you have had any of the following surgeries:

Cardiac/Bypass Surgery _____ Tracheostomy _____ Uvuloplasty (UPPP) _____

Nasal septal surgery or rhinoplasty _____ Tonsillectomy _____

Lung Surgery(indicate type) _____ Other: _____

Medical Conditions: Check if you have or have had any of the following problems or conditions.

Heart Problems	Lung Problems	Sleep Problems	Other
<input type="checkbox"/> Angina / Chest Pain	<input type="checkbox"/> Asthma	<input type="checkbox"/> Snoring	<input type="checkbox"/> Depression
<input type="checkbox"/> Palpitations	<input type="checkbox"/> COPD	<input type="checkbox"/> Fall asleep slowly	<input type="checkbox"/> Anxiety
<input type="checkbox"/> /Arrythmia	<input type="checkbox"/> Use oxygen	<input type="checkbox"/> Fall asleep quickly	<input type="checkbox"/> Thyroid problem
<input type="checkbox"/> Heart attack/ MI	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Wake up frequently	<input type="checkbox"/> Seizures
<input type="checkbox"/> Heart Failure/CHF		<input type="checkbox"/> Sleep walking	<input type="checkbox"/> Heartburn/GERD
<input type="checkbox"/> High Blood pressure		<input type="checkbox"/> Sleep talking	<input type="checkbox"/> Stroke
<input type="checkbox"/> Pacemaker: rate _____			<input type="checkbox"/> Arthritis
<input type="checkbox"/> Atrial Fibrillation			<input type="checkbox"/> Cancer
			<input type="checkbox"/> Fibromyalgia
			<input type="checkbox"/> Diabetes

OTHER PROBLEMS: _____

Due to HIPAA guidelines we will not share any information (scheduling or medical) with anyone but you unless we have written permission. If you wish to give permission for us to speak to anyone other than yourself, please list them here and sign below.

Name _____ relationship _____

Name _____ relationship _____

I understand I will be undergoing a sleep test (polysomnography). I understand there may be video monitoring during the set up or monitoring. I authorize payment of benefits from the government and /or my insurance company, to Tri-County Medical Associates for services rendered. I also authorize the release of any medical or other information necessary to process claims.

I authorize Tri-County Sleep Center to leave messages on my answering machine at the following phone numbers:

Home YES/NO _____, Cell YES/NO _____

I understand that messages may contain protected health information, including diagnosis and treatments about me.

****Signed _____ Date _____