## SLEEPMED ARES Questionnaire ©



Last Na	ame		ITHIN THE F	irst Name	Middle	e Initial	G Male	ender Fe	male		Tally Risk
											Neck +2 Ma
Month	Day	Year		Pounds		Feet	Inches		In	ches	+2 Fe
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					I.D. I	<b>Number</b> (o	ptional)				
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Have you been diag	nosed or t	reated for	any of the	following	conditions	?					res
High blood pressur	0 1/		Stro	ko			Va			1.5	Score
	_	No					Yes				
Heart disease	Yes	No		ression			Yes	S N	0		
Diabetes	Yes	No	Slee	p Apnea			Yes	s N	0		
Lung disease	Yes	No	Nas	al oxygen	use		Yes	s N	0		
Insomnia	Yes	No	Res	tless legs :	syndrome		Yes	s N	0		Do n
Narcolepsy	Yes	No	Mor	ning Head	aches		Yes	s N	0		the
	Yes	No				odin ovu	contin Ye	s N	0	198	,
Sleep Medication	, 163	140	Faii	i Medicalic	on e.g. vici	Julii, Oxyc	Jonath 10				
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If points total =3 or lower (no risk) 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)

SM - 0073 Rev.03



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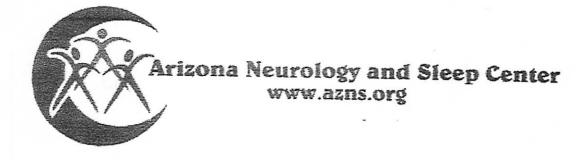
At **Arizona Neurology and Sleep Center** we are always striving to improve our patient's health by staying current in both our techniques and diagnostic equipment. Recently we purchased a new technology that will allow you, the patient, to have your sleep studied in the comfort of your own home. Many of our patients were uncomfortable with the cost and process of outpatient sleep laboratories and we are excited to bring this new, easy to use and economical solution to our patients.

While the monitoring device is in my possession, I agree to exercise care in its use and handling, and return it within the promised time frame in working condition. I understand that delays in its return causes problems for other patients who need this service.

## **FINANCIAL RESPONSIBILTY**

I understand that if the device is lost, stolen or damaged while in my possession, I am responsible to pay **Arizona Neurology and Sleep Center** for the replacement of this device. The charge for replacing the Home Sleep Test is \$ 995.

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	(uale) (before 1 portunity to be tes	100 35 1010 It 100 not ro	ee to return it on f my sleep test so that other pa turn it by the date above I agre	 itients e to
Patient Name				
Patient Signature				
Date			A. A	



## SLEEP STUDY CONSENT FORM HOME STUDY

- My physician has explained the sleep study to me as well as the benefits and risks of having the test performed.
- I have had the opportunity to ask my physician and my sleep technologist questions, and I consent to the sleep study.
- I was shown in detail and in-person how to apply the Home Sleep Testing equipment by a Registered Polysomnographic Technologist (RPSGT) as well as given reference materials to take home with me and given the number to the night sleep technologist on duty.
- I will bring back the Home Sleep Testing Equipment (Apnea Link) the morning after my sleep study or I will be charged for the equipment which could be up to \$2000.

Print Patient Name:		
Patient Signature:		
Date:		
Signature of Parent/Conservator		
Relationship:		
Hospital Witness:		