New Patient Instruction Sheet

This appointment has been reserved for you. Please provide at least 24 hour notice by calling us if you are unable to keep this appointment. A new patient appointment cancelled on the same day or no-showed Will Not be rescheduled except in cases of true emergency and you will be charged a fee.

1. It is **VERY important that you bring ALL your Medications** (Prescriptions, vitamins, over-the-counter medications, herbal supplements, etc.) to your appointment. **Bring the medications in their actual containers. Do not bring a list.**
2. Please complete the enclosed paperwork and bring it with you to your appointment. Do not mail it to our office.
3. Please bring your photo ID and insurance card with you to your appointment.
4. If you have a CPAP machine please bring it to your appointment.
5. Please arrive and check in 30 MINUTES before your scheduled appointment time.

We look forward to seeing you. Please call if you have any questions about your appointment or are in need of directions. We suggest you call your insurance company to verify your deductible and out of pocket expenses regarding a sleep study.

Thank you for choosing us for your health care needs.

April Merrill, APRN-CNS, DNP, CCNS
Doctor of Nursing Practice

INTEGRIS

Sleep Medicine Clinic
4221 S. Western, Suite 3030 • Oklahoma City, OK 73109
Office: 405-951-2141 • Fax: 405-636-7247
integrisok.com/sleep-medicine

Epworth Sleepiness Scale

Name _____

Date _____

Your age: (Yr) _____ Your sex: ◯ Male ◯ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't 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 (e.g. a theatre or a meeting)	
As 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 a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Score	
0-10	Normal
10-12	Borderline
12-24	Abnormal

Insomnia Severity Index (ISI)

Name _____ Date_____

For each question below, please circle the number corresponding to your response.

1 Please rate the current (I.E., last month) **SEVERITY** of your insomnia problem(s).

	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep:	0	1	2	3	4
Difficulty staying asleep:	0	1	2	3	4
Problem waking up too early:	0	1	2	3	4

2 How **SATISFIED**/dissatisfied are you with your current sleep pattern?

Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
0	1	2	3	4

3 To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)

Not at all Interfering	A Little Interfering	Somewhat Interfering	Much Interfering	Very Much Interfering
0	1	2	3	4

4 How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little Noticeable	Somewhat Noticeable	Much Noticeable	Very Much Noticeable
0	1	2	3	4

5 How **WORRIED**/distressed are you about your current sleep problem?

Not at all	A Little	Somewhat	Much	Very Much
0	1	2	3	4

Guidelines for Scoring/Interpretation:
Add the scores for all questions.

Total score categories:	
0-7	No clinical significant insomnia
8-14	Sub threshold insomnia
15-21	Clinical insomnia (moderate severity)
22-28	Clinical insomnia (severe)

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Sleep Medicine

Sleep Disorder Assessment

- Main problem you're having? _____
- Do you snore? **YES NO,** Have you been told that you snore loudly? **YES NO**
- Have you been told that you stop breathing or hold your breath while sleeping? **YES NO**
- Do you wake up suddenly gasping for breath or unable to breathe? **YES NO**
- Do you have problems falling asleep? **YES NO**
- Are you currently taking any medications to help fall asleep? **YES NO N/A**
  If yes, please list which medications:
  RX?_____ **Over The Counter?**_____
- Does it help? **YES NO N/A**
- If no, have you ever taken medication to help you fall asleep? **YES NO**
  if yes, what medication? _____ Did it help? **YES NO**
- Do you have problems falling asleep because you feel like you have to move your legs? **YES NO**
- Do you wake up at night because you feel like your legs are on fire, itch or have a crawling sensation? **YES NO**
- Do you see vivid dream-like images just **before** falling asleep **YES NO**
- Do you have problems staying asleep? **YES NO**
- Do you see vivid dream-like images just **after** falling asleep? **YES NO**
- Do you get up at night to go to the bathroom? **YES NO**
  If yes, how many times? _____
- Are you still tired when you first wake up in the morning after sleeping all night? **YES NO**
- Are you tired during the day? **YES NO**

TURN OVER

- Do you fall asleep when driving? **YES NO**
- Do you fall asleep when riding in a car? **YES NO**
- Do you fall asleep while watching TV? **YES NO**
- Do you fall asleep at work? **YES NO**
- Do you fall asleep during lunch or at a break? **YES NO**
- Do you fall asleep when reading? **YES NO**

- Are you often unable to move (paralyzed) when you wake up in the morning? **YES NO**

- Do you wake up with a headache? **YES NO**

- Do you have decreased memory or concentration? **YES NO**

- Do you ever get sudden muscle weakness when laughing, angry or in situations of strong emotion? **YES NO**

- Do you have a feeling of weariness, tiredness, or lack of energy? **YES NO**

- Do you take intentional naps? **YES NO If yes, how long-min/hours?** _____
  If yes, how many naps a week? _____
- If ***YES***, do you feel refreshed after a nap? **YES NO**

- What time does your work shift start? _____**AM/PM**; What time does your shift end? _____ **AM/PM**

- What time do you ***typically*** go to bed?
  Weekday: AM/PM Weekend: AM/PM

- What time do you ***typically*** awaken for the day?
  Weekday: AM/PM Weekend: AM/PM

- Give an ***average*** of hours ***you feel like*** you have slept ***per*** night, (***we know it varies so give your best estimate***)
  Weekday: Weekend:

- Have you ever had a sleep study? **YES NO**
  If yes, what year_____ **where:** _____
- Do you currently use a CPAP machine? **YES NO N/A**
- **If no, reason discontinued:** _____

- Do you sleep in a Bed – Flat or adjustable **OR**
  Recliner - Flat or sitting up at what angle?
- Do you sleep with head or legs propped or elevated?

Sleepiness and Driving

Excessive daytime sleepiness (EDS) is the result of many different sleep problems and it can cause impaired human performance. We are obligated to inform you about EDS due to the potential for increased accidents and injuries.

If you fall asleep while driving and you get into an accident, there is an 86% chance that someone will die. Every year over 100,000 automobile accidents and 1,500 automobile fatalities are related to someone driving while they are fatigued and sleepy. These are conservative estimates and the actual numbers are most likely greater. Obviously, it is dangerous to be sleepy in any situation that requires alertness. EDS represents a significant health hazard that you need to understand.

Please don't become a statistic!

I recommend that you drive only when fully alert. If you become drowsy while driving, you should pull off the road safely. Return to driving only when you are clearly awake. Some people find a brief nap, a brisk walk, or a cup of coffee will help to become more alert.

There are significant legal and social obligations associated with the safe operation of your motor vehicle. You need to inform us if you are unable to follow our recommendations regarding driving and sleepiness.

Share this information with a friend and you may save his or her life.

Please date and sign below indicating that you have read and understand this information.

_____ _____

PATIENT SIGNATURE DATE

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Medical Group
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Shift Work Sleep Diary

Patient Name:

Date	Meds, alcohol, etc.	8 pm	9 pm	10 pm	11 pm	MN	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	Noon	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm

Date	Meds, alcohol, etc.	8 pm	9 pm	10 pm	11 pm	MN	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	Noon	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm
											↓		—	—		—	—	—	—	—	↑				

Fill in the time you are asleep. ↓ = in bed; ↑ = out of bed

In the example above, the person got into bed at 5:30 AM, fell asleep at 7:00 AM, awoke (and stayed in bed) at 9:00 AM, fell back asleep at 10:30 AM, slept until 3:00 PM and got out of bed at 3:30 PM.

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Sleep Diary

Patient Name:

Date	Meds, alcohol, etc.	Noon	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	MN	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am

Date	Meds, alcohol, etc.	Noon	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	MN	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am
											↓		—	—			—	—	—	—	↑				

Fill in the time you are asleep. ↓ = in bed; ↑ = out of bed

In the example above, the person got into bed at 9:30 PM, fell asleep at 11:00 PM, awoke (and stayed in bed) at 1:00 AM, fell back asleep at 2:30 AM, slept until 7:00 AM and got out of bed at 7:30 AM.

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