

MID-SOUTH PULMONARY SPECIALISTS SLEEP CENTER

5050 POPLAR AVENUE, SUITE 700

MEMPHIS, TN 38157

(901) 276-6507

WWW.MSPULMONARY.COM

Dear _____.

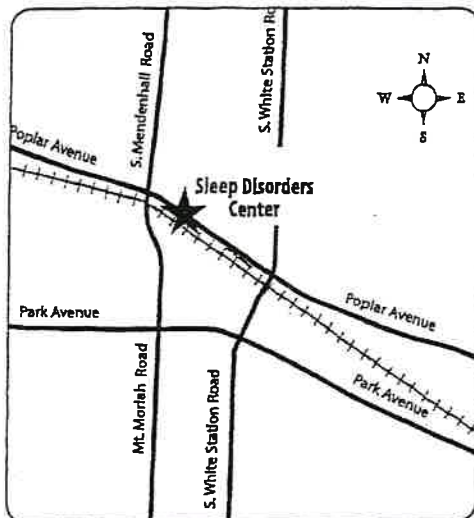
This confirms your appointment for an evaluation with a sleep specialists, **Dr. Robert Aguillard, Dr. James Andrews, Dr. Crystal Stanton, Dr. Merrill Wise, Dr. David Williams, Dr. S. Junaid Zaidi, or Mr. Errol Hook, ACNP** at Methodist Healthcare Sleep Disorders Center.

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY _____ at _____ A.M./P.M.

In order to evaluate you properly we require that you accurately complete the enclosed questionnaire and forms and bring with you to your appointment. Please allow up to two hours for your appointment. On the day of your appointment, please arrive 15 minutes before your appointment time. You will need to go to the Sleep Disorders Center, which is located on the 7th floor of the White Station Tower/I-Bank Building in East Memphis. The Sleep Disorders Center is located at 5050 Poplar Avenue, Suite 700, Memphis, TN 38157. **Parking is adjacent to the White Station Tower/I-Bank Building.**

Please bring your **Insurance Card** and the **completed packet you received prior to your appointment.** The Sleep Disorders Center requires payment of deductibles, co pays, out of pocket fees for all testing procedures (i.e., sleep studies) before we will schedule any procedures. You may pay by check, cash or credit card.

RESCHEDULING: If you cannot keep your appointment, please call the Sleep Disorders Center at **901-276-6507** between the hours of **8:00 a.m. – 4:30 p.m.** at least 24 hours in advance.



5050 Poplar Avenue, Suite 700
Memphis, TN 38157
(located in i-Bank Tower)

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.

5050 POPLAR AVENUE, SUITE 800

MEMPHIS, TN 38157

(901) 276-2662

PATIENT INFORMATION

NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS		ETHNICITY
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER	CITY, STATE ZIP		RACE
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE
SEXUAL ORIENTATION		PREFERRED PRONOUN	GENDER IDENTITY				
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)			
ADDRESS				ADDRESS			
CITY, STATE ZIP				CITY, STATE ZIP			
WORK PHONE				WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)			SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY#			
NAME OF INSURED			GROUP#			
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$			
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE		EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#			
NAME OF INSURED		SSN#	BIRTHDATE	GROUP#		
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$			
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE		EXPIRATION DATE	

I authorize medical treatment by my physician. I agree to pay all cost associated with collecting services in the event I fail to pay the balance due. I authorize payment of Medicare/Medicaid and other health ins. benefits be made on my behalf. I authorize the release of my medical information to CMS, insurance companies or their agent all information needed to determine benefits for services rendered. This authorization remains in effect until I revoke it in writing.

SIGNATURE OF PATIENT/GUARDIAN _____

DATE _____

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: _____

SS#: _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION CONTAINED IN MY MEDICAL RECORD TO THE FOLLOWING PERSONS:

I authorize the practice to disclose or provide protected health information directly to me at the email address, fax number, phone number, cell phone number, or alternative address that I have indicated below. I am also allowing Mid-South Pulmonary Specialists to leave a message on my answering machine or with the person answering the telephone regarding appointments, etc. I understand that it is my responsibility to notify the practice of my preferred method of communications or any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, and carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Cell phone: email address: mail: fax number: other phone: text message:

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- Entire patient record; or, check only those items of the record to be disclosed:
- Office notes
- Lab results, pathology reports
- X-rays
- Financial history report (previous 3 yrs. only)
- Nursing home, home health, hospice, and other physician records
- Only send the following: _____

PURPOSE OF DISCLOSURE (please state the purpose of the disclosure or check patient request):

Patient Request Other (please specify): _____

When requesting information to be disclosed, please specify the format in which you would like the PHI provide to you. We will accommodate your request, if possible. Please be advised that there may be costs involved in providing the PHI requested.

Paper copy electronic copy via the following: CD flash drive other means: _____

By signing below, I agree with the following information:

Expirations or termination of authorization – This authorization will need to be renewed every twelve (12) months, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

Please list desired expiration date: _____

Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in-person or by mailing a written request to the practice, attn.: Compliance Office.

Non-Conditioning statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

Re-disclosure Statement: I understand that the practice has no control regarding persons who may have access to the mailing address, email address, telephone, cell or fax number I have designated to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be the responsibility of this practice.

I understand that authorizing disclosure of this health information is voluntary. I do not need to sign this form to assure treatment. HOWEVER, IF THIS AUTHORIZATION IS NEEDED FOR PARTICIPATION IN A RESEARCH STUDY, MY ENROLLMENT IN THE STUDY MAY BE DENIED. Also, if this authorization is needed for the sole purpose of creating protected health information to disclose to a third party, my treatment may be denied.

I understand I am entitled to a copy of this form. I have seen and had an opportunity to read the notice of privacy practices for health related information.

Signature of patient or legal representative

Date

Relationship to patient

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
MEDICATION VERIFICATION SHEET

PATIENT NAME _____

CHART/MRN# _____

DATE OF VISIT _____

ALLERGIES: _____

NAME OF PHARMACY _____

Pharmacy Phone # _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.
(INCLUDING INHALERS AND VITAMINS)

<u>MEDICATION NAME</u>	<u>DOSAGE/STRENGTH/MG</u>	<u>FREQUENCY (times per day)</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____

ARE YOU CURRENTLY TAKING ANY FORM OF BIRTH CONTROL? YES NO

SIGNATURE

DATE

Insomnia Severity Index

Name: _____

Date: _____

MRN: _____

The insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the "Guidelines for scoring/interpretation" below to see where your sleep difficulty fits.

For each question, please Circle the number that best describes your answer.
Please rate the *CURRENT* (i.e. last 2 weeks) *SEVERITY* of your insomnia problem(s).

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

4. How **SATISFIED/DISSATISFIED** are you with your CURRENT sleep pattern?

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

5. How **NOTICEABLE** to others do you think your sleep problem is in terms of impairing the quality of your life?

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

6. How **WORRIED/DISTRESSED** are you about your current sleep problem?

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

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

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

Guideline for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = _____ total score

Total Score Categories:

0-7 = No clinically significant insomnia

8-14 = Subthreshold Insomnia

15-21 = Clinical insomnia (moderate Severity)

22-28 = Clinical insomnia (Severe)

PATIENT QUESTIONNAIRE
MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.

NAME: _____

DATE: ___/___/___

Referring Physician: _____ Primary Care Physician: _____

Marital Status: _____ Age: _____ Height: _____ Weight: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

PAST MEDICAL HISTORY (Place check Yes or No beside all conditions that apply to you.
 If you have other conditions, please write them down in the space provided.

<u>Condition</u>	<u>YES</u>	<u>NO</u>	<u>Condition</u>	<u>YES</u>	<u>NO</u>
Atrial Fibrillation			Heart Disease		
Asthma			Hypertension		
Cancer;			Insomnia		
Where?			Lupus		
Seizure(s)			Restless Leg Syndrome		
Congestive Heart Failure			Sleep Apnea		
COPD			Stroke		
Coronary Artery Disease			Thyroid Disorder		
On Oxygen			Floppy/Droopy Eyelids		
Neurodegenerative Disorder: MS; Parkinson's; Alzheimer's; Other:			Neuromuscular Disorder: Muscular Dystrophy, Myasthenia Gravis, ALS, Peripheral Neuropathy; Other:		
Diabetes			Depression		
Dysrhythmia/Heart Rhythm Problem			Elevated Red Blood Cell Count (Polycythemia)		

PAST SURGICAL HISTORY Please list all surgeries you have had.

<u>SURGERY</u>	<u>DATE</u>	<u>SURGERY</u>	<u>DATE</u>

Name: _____ DOB: _____

FAMILY HISTORY Please check all that apply.

<u>Condition</u>	<u>YES</u>	<u>Condition</u>	<u>YES</u>
Asthma		Sleep Apnea	
Cancer		Stroke	
Where?		Thyroid Disorder	
COPD		Heart Disease	
Diabetes		Other:	
Hypertension			

SOCIAL HISTORY Please check all that apply.

	<u>YES</u>	<u>NO</u>
Do you smoke?		
How many years have you smoked?		
Are you a former smoker?		
When did you quit smoking?		
Have you tried to quit?		
Do you drink alcohol?		
How many alcohol drinks per day?		
What is your occupation?		

When was your last flu shot? _____

Have you had a pneumonia shot? YES NO When? _____

Do you have a Living Will or Advance Directive? YES NO

Name: _____ DOB: _____

THE EPWORTH SLEEPINESS SCALE

Use the following scale to rate how likely you are to doze or fall asleep during each of the following situations. This refers to your usual way of life in recent times.

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

	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (a theater, meeting, seminar)	_____
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 traffic	_____
SCORE:	<input type="text"/>

1. Why are you seeing a sleep specialist? _____
2. How long has this problem bothered you and how often does it occur? _____
3. Do any other members of your family have sleep problems? _____

Please check ALL that apply:

- | | |
|---|--|
| Awaken short of breath, choking or gasping _____ | History of Tonsillectomy _____ |
| Awaken with heartburn, belching, or coughing _____ | Fall asleep or doze while driving _____ |
| Have crawling/aching feelings in legs _____ | Wake with stiff, sore/aching muscles _____ |
| Sweat excessively at night _____ | Have vivid dream-like scenes upon awakening/falling asleep _____ |
| Fall asleep when laughing/crying _____ | Frequent Headaches _____ |
| Notice parts of your body jerking _____ | Problems with focus & attention _____ |
| Kick during the night _____ | Memory Problems _____ |
| Wake with pain in neck, spine, joints _____ | Have loss of muscle tone when extremely emotional _____ |
| Have morning jaw pain _____ | Snore Loudly _____ |
| Notice heart pounding, beating irregularly day/night _____ | Grind teeth during sleep _____ |
| Feel unable to move/paralyzed when waking or falling asleep _____ | Bedwetting _____ |
| Problems at school/work because of sleepiness _____ | Fall asleep during the day _____ |

Name: _____ DOB: _____

5. Does your sleep problem interfere with your social life/activity? How? _____

6. How many hours of sleep do you usually get per night? _____
7. What time do you usually go to bed on Weekdays? _____ Weekends? _____
8. How long does it take for you to fall asleep? _____
9. How many times do you typically wake up at night? _____
10. What time do you get up in the morning on WEEKDAYS? _____ WEEKENDS? _____
11. What disturbs your sleep? _____
12. With whom are you now living? (wife, husband, children, parents, etc., please list ages)

13. Occupation? _____ Do you work split shifts or rotating (variable) shifts? _____
14. Do you drink coffee or tea within 2 hours before you go to bed? () YES () NO
15. Do you do physical exercise before bedtime? () YES () NO
16. Do you read and/or watch TV before falling asleep? () YES () NO
17. Do you take naps during the afternoon or evening? () YES () NO
18. Do you wake from naps feeling rested? () YES () NO
19. Have you ever been knocked unconscious or had serious injury to your head? () YES () NO
Please Explain _____

20. **CIRCLE IF YOU HAVE YOU EXPERIENCED ANY OF THE FOLLOWING RECENTLY:**

Depression	Anger	Anxiety	Loneliness	Suicidal Thoughts
Hopelessness	Fears	Fatigue	Nightmares	Low self-esteem

24. Have you attempted suicide in the last six months? _____
25. Are you contemplating causing harm to yourself at this point and time? _____
26. Have you been under the care of a mental health practitioner (e.g., psychiatrist, psychologist) in recent time's or currently? _____ If yes, who? _____
29. Have you had a sleep study before? YES NO When and Where? _____
30. Do you have a CPAP Machine? YES NO If yes, where was it purchased? _____