COMPREHENSIVE SLEEP ASSOCIATES OF NJ

NAME _____ DATE _____

DATE OF BIRTH _____ REFERRED BY _____

Please check all that apply to you.

I AM SEEKING EVALUATION FOR;

- ☐ Snoring
- ☐ Gasping episodes
- ☐ Difficulty staying asleep
- ☐ Difficulty initiating sleep
- ☐ Restless sleep
- ☐ Dream enacting behavior
- ☐ Excessive sleepiness/ Fatigue
- ☐ Not feeling refreshed on awakening
- ☐ Frequent leg movement
- ☐ Restless legs
- ☐ Treatment of sleep apnea previously diagnosed
- ☐ Witnessed apnea
- ☐ OTHER: _____

HOW LONG HAS SYMPTOM BEEN PRESENT?

- ☐ _____ Years
- ☐ _____ Months
- ☐ Since _____

SNORING HAS BEEN NOTICED

- ☐ Since gaining weight
- ☐ Since childhood
- ☐ For __ years
- ☐ For an unknown duration

MY SLEEP SCHEDULE

Off day bedtime is _____

Usual amount of time to fall asleep is_____

Time to get out of bed on off day is _____

Total # of hours of sleep is _____

Work day bedtime is _____

Usual amount of time to fall asleep is _____

Time to get out of bed on work day is _____

Total # of hours of sleep is_____

SLEEPINESS AT WORK

- ☐ Does not occur
- ☐ Occurs rarely
- ☐ Occurs frequently

NAPPING

- ☐ Occurs frequently
- ☐ Occurs occasionally
- ☐ Would occur if the opportunity were there
- ☐ Is present and I sometimes nap at lunch

SLEEPINESS WHILE DRIVING

- ☐ Never occurs
- ☐ Rarely occurs
- ☐ May occur after driving a long distance
- ☐ Can occur after driving _____

AWAKEN DURING MY SLEEP HOURS

_____ Times per night

I AM ABLE TO RETURN TO SLEEP

- ☐ Usually within ____ minutes
- ☐ Usually within ____ hours
- ☐ Easily
- ☐ With difficulty due to _____

SNORING IS

- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Uncertain
- ☐ Not present

I AWAKEN WITH A GASPING SENSATION

- ☐ Occasionally
- ☐ Frequently
- ☐ Never as far as I know

APNEA EPISODES HAVE BEEN WITNESSED

- ☐ Yes
- ☐ No

MY USUAL SLEEP POSITION IS

- ☐ Side
- ☐ Back
- ☐ Stomach
- ☐ All positions
- ☐ In a recliner

AWAKENINGS ARE CAUSED BY

- ☐ Bed partner behavior
- ☐ Family needs such as _____
- ☐ Unknown reasons
- ☐ Need to use the bathroom
- ☐ Breathing problems
- ☐ Physical discomfort

COMPREHENSIVE SLEEP ASSOCIATES OF NJ

NAME _____ DATE OF BIRTH _____

HAVE TRIED THESE THINGS TO HELP MY SYMPTOMS

- ☐ PAP Machine _____
- ☐ Surgery
- ☐ Oral appliance
- ☐ Nasal Strips
- ☐ Medications _____
- ☐ OTHER: _____

SLEEP PROBLEMS ARE IMPROVED WITH

- ☐ Using PAP therapy
- ☐ When sleep alone
- ☐ Medication
- ☐ Since weight loss
- ☐ Sleeping on side
- ☐ Since surgery
- ☐ Oral appliance
- ☐ With nothing so far
- ☐ OTHER: _____

SLEEP PROBLEMS ARE WORSE WITH

- ☐ No Medication
- ☐ Stress
- ☐ Anxiety
- ☐ Alcohol
- ☐ Caffeine
- ☐ Inadequate sleep
- ☐ Shift work
- ☐ Frequent bathroom trips
- ☐ Nasal congestion
- ☐ Pain
- ☐ Bed partner behavior
- ☐ Worry or racing thoughts

BATHROOM TRIPS OCCUR DURING SLEEP HOURS

_____ Times per night

HAVE ALSO BEEN TOLD ABOUT

- ☐ Violent behavior during sleep
- ☐ Sleepwalking
- ☐ Sleep talking
- ☐ Frequent body position changes during sleep
- ☐ Leg kicking during sleep
- ☐ Flailing limb movement
- ☐ OTHER:

COMPREHENSIVE SLEEP ASSOCIATES OF NJ

NAME _____ DATE _____

DATE OF BIRTH _____ REFERRED BY _____

Please check ALL that apply to your child.

SEEKING EVAULATION FOR

- ☐ Snoring
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Daytime sleepiness
- ☐ Sleep Walking
- ☐ Difficulty focusing or irritability
- ☐ Difficulty breathing during sleep
- ☐ Evening/ nighttime leg discomfort
- ☐ Kicking during sleep
- ☐ Screaming or extreme fright during sleep

SYMPTOMS HAVE BEEN PRESENT

- ☐ Nightly
- ☐ _____times per week
- ☐ Since infancy
- ☐ _____ Years

BED TIME

_____on school days

_____on non-school days

SLEEP ONSET

_____ Minutes

_____Hours

WAKE UP TIME

_____on school days

_____on non-school days

SLEEP PROBLEM IS

- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Stressful to child
- ☐ Stressful to caregivers
- ☐ Compromising to function at school

DURING THE NIGHT

Child wakes up _____ nights per week

Child wakes up _____ times per night

Child gets back to sleep within_____ Minutes

- ☐ Comes into parent's room to sleep
- ☐ Does not usually wake up during the night
- ☐ Needs parental intervention to return to sleep
- ☐ Difficult to wake in the morning for school

ASSOCIATED SYMPTOMS

- ☐ Sleep Walking
- ☐ Leg discomfort before / during sleep
- ☐ Nightmares
- ☐ Bedwetting
- ☐ Headaches upon waking up
- ☐ Poor school performance

SYMPTOMS IMPROVE IF

- ☐ Medication is given to induce sleep
- ☐ Medication is given to stimulate alertness
- ☐ Patient takes OTC sleep aid or herbal medication
- ☐ Parent is in the room
- ☐ Sharing a bed with the parent
- ☐ When child is not in school
- ☐ Medication is given to treat allergies or nasal congestion
- ☐ When nasal Congestion is not present
- ☐ When child has longer sleep hours
- ☐ Increased physical activity during the day
- ☐ _____

COMPREHENSIVE SLEEP ASSOCIATES OF NJ

NAME _____ **DATE OF BIRTH** _____

SYMPTOMS ARE WORSE IF

- ☐ Electronic devices/ video games used shortly before bedtime
- ☐ Watching TV in bedroom
- ☐ Sleeping alone in bedroom
- ☐ Sharing a room with other children
- ☐ Sleeping away from home
- ☐ Pets are in bedroom
- ☐ Nasal congestion is present
- ☐ Stress level increases
- ☐ Drinking caffeine
- ☐ Sleep hours are reduced
- ☐ Diet is high in sugar
- ☐ Nightmares occur
- ☐ Exposed to smoke
- ☐ _____

COMPREHENSIVE SLEEP ASSOCIATES OF NJ
1401 Whitehorse - Mercerville Rd. Suite 219
Hamilton, NJ 08619
Phone#:609-584-5150
Fax#:609-584-5144

RELEASE OF SLEEP STUDY TEST RESULTS

Comprehensive Sleep Associates recognizes the importance of prompt review and communication of test results to ensure accurate diagnoses, effective attention and treatment, and optimal patient care. Sleep study test results will be reviewed with your sleep provider at the time of your test result appointment.

Once tests results are reviewed, please forward a copy to:

☐Myself

☐Provider: _____

Patient Name: _____

Patient's Signature: _____

Date: _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent time. 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 (e.g. a theater 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 lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

NAME _____ **DATE** _____

DATE OF BIRTH _____

COMPREHENSIVE SLEEP ASSOCIATES OF NEW JERSEY

Callum M. Dupre, DO

Dr. Dupre is the practice lead physician and medical director of the sleep center. He is board certified in Sleep Medicine and Neurology. He received his medical degree from the New York College of Osteopathic Medicine and performed his residency and chief residency in neurology at North Shore Long Island Jewish Medical Center in Manhasset, NY. He subsequently completed a fellowship in sleep medicine at the Mayo Clinic in Rochester, Minnesota. He is a member of the American Academy of Neurology as well as the American Academy of Sleep Medicine.

Subooha Zafar, MD, FAASM

Dr. Zafar is board certified in critical care, internal medicine, sleep medicine, and pulmonary medicine. She earned her medical degree at Jefferson Medical College and completed residency at the New York University Medical Center. She received her fellowship training in pulmonary and critical care, as well as sleep medicine, from the New York University of Medicine.

Kerri Penders, MSN, C-ANP, RRT

Kerri Penders received her Bachelor of Science degree from SUNY, Stony Brook, NY, and then completed her Master's degree from Molloy College, NY. She is a licensed respiratory therapist and board certified nurse practitioner with more than 20 years of health care experience. Her history as a registered nurse includes cardiac, pulmonary, intensive care, and clinical coordinator for research studies with the National Institute of Health. She is certified in clinical sleep health and has been a nurse practitioner at Capital Health since 2004.

Swetha Voddi, MD

Dr. Voddi is board certified in Sleep Medicine and Family Medicine. She underwent her medical training in India and then completed her residency at Trover Health Foundation in Kentucky, where she was also chief resident. She then worked as a Primary Care Physician in New York, and then at Albert Einstein Medical Center in Philadelphia. Following this she completed her fellowship in Sleep Medicine at the University of Michigan in Ann Arbor. She is a member of the American Academy of Family Physicians and the American Academy of Sleep Medicine.

Dessislava Dimitrova, MD, PhD, FACP

Dr. Dimitrova is board certified in Internal Medicine and board eligible in Sleep Medicine. She earned her medical degree (MD) and doctorate (PhD) in immunology from the Medical University of Sofia, Bulgaria and completed residency training in internal medicine and training in sleep medicine at Capital Health System. She is a Fellow of The American College of Physicians. She is author and co-author of more than 20 publications in well recognized scientific journals. She is fluent in Bulgarian.

Roseline I. Adunbarin, DNP, APN, FNP- BC

Roseline Adunbarin is a Board Certified Family Nurse Practitioner. She obtained her initial Nursing degree from the University of Bradford, United Kingdom; and then completed her Doctor of Nursing Practice at Temple University, PA. Her background nurse practitioner experience is in Primary Care, following her career as a registered nurse. Prior to her nursing career, she worked as a Civil Engineer. She earned her Bachelor of Science in Civil Engineering from the University of Ilorin, Nigeria.

WHAT TO EXPECT AT THE SLEEP CENTER

After you are evaluated by a sleep specialist you may be scheduled for a sleep study. You will have a private bedroom, bathroom, TV and WIFI. The technologist will be outside the bedroom monitoring you all night and will be available to you in case you need anything. The testing is non-invasive with no needles, x-rays or medications given. If you need to take any medication, please bring it with you. Let the technologist know what medication you take while in the Sleep Center. In some cases a daytime test called a Multiple Sleep Latency Test (MSLT) may be requested on the day following the overnight sleep study. If we feel an MSLT might be indicated, information will be given to you about it when you schedule your tests.

In the morning the technologist will have limited information as to whether you had significant sleep apnea or not. Your sleep provider will discuss your test results with you at your follow up visit.

If sleep apnea is identified during the sleep study, you may be advised to have a CPAP (continuous positive airway pressure) titration on a subsequent night.

After your CPAP titration has been completed the results will be analyzed and interpreted. A typical sleep study may contain over 1,000 pages of data and takes some time for analysis and scoring by the technologist and review and interpretation by a sleep specialist. Once your studies have been interpreted we will contact a home care company to set up your new CPAP machine. When they receive approval from your insurance company, they will contact you to deliver the equipment to your home and demonstrate how to use the equipment properly. Generally it will take about several weeks from the time you are in the sleep center for your CPAP trial until you receive your equipment from the homecare company.

We will work diligently in getting your studies completed and analyzed so that you may start your treatment plan as soon as possible. Please call us at (609)584-5150 if you have any questions regarding your studies and treatment options

Capital Health

General & Financial Consent: Inpatient, Outpatient, Emergency Department

Financial Agreement: I agree whether I sign as a representative of the patient or as the patient, that in consideration of the services to be rendered to me, I obligate myself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. I intend to be legally bound, assume full responsibility for, and agree to pay Capital Health upon presentation of the bill, all expenses, and charges for such services and care. Should the account be referred to an attorney for collection, I shall reimburse Capital Health reasonable attorney's fees and collection expense.

Medicare Authorization for Information and Payment Request Release: I agree the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers or to the Professional Review Organization any information needed in order to process payment for this visit or a related Medicare claim. I request that payment or authorized benefits be made on my behalf, if I am a member of a Medicare Risk Contracting Health Maintenance Organization.

Release of Information: I assign benefits payable for hospital and physicians' services to the physician or provider furnishing the service and authorize such physician or provider to submit a claim containing information related to my treatment, to Medicare, Medicaid or other Insurance Carrier for payment. I understand that if under Medicare Program Guidelines, as necessary, Capital Health is required by various governmental agencies to review and release patient information. Capital Health also cooperates with various agencies by providing statistics and medical information for research purposes. I understand and agree that Capital Health is authorized to review and release such information.

I understand that these records will contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Any specimens taken from my body during my treatment may be retained, preserved, used for teaching purposes, or disposed by Capital Health.

Consent to Release Medical Records: I authorize the release of my medical records and information for the purpose of coordinating care and discharge planning and for the purpose of my follow-up care, this includes the designated Caregiver, if elected. I understand that the information disclosed may include Specially Protected Health Information such as records of psychiatric treatment, counseling or testing, substance abuse counseling or treatment, and or HIV, AIDS diagnosis, treatment, or testing. I may revoke this authorization as it relates to Specially Protected Health Information by providing written notice to Capital Health, Health Information Management Department.

Consent for Blood Test: In the event a physician, hospital employee, worker, student, or other person is accidentally stuck with a needle or otherwise directly exposed to my blood or body fluids in connection with my treatment at Capital Health or during the discharge process, I consent to having my blood drawn and tested for Human Immunodeficiency Virus (HIV, the virus that causes Acquired Immune Deficiency Syndrome, AIDS), Hepatitis B virus, and Hepatitis C virus. Such testing will allow any necessary treatment of the physician, hospital employee, worker, student, or other person to begin without delay. I further understand that if such testing is required I will receive appropriate counseling. The results of the test will be released only to those involved with the medical treatment of the exposed physician, hospital employee, worker, student, or other person as required by law or as agreed to by me.

Information about Doctors at Capital Health: Some physicians and other health care providers who participate in your care, including but not limited to, for example, surgeons, radiologists, anesthesiologists, pathologists, pediatricians, and consultants are private practitioners and not employees or agents of Capital Health. Physicians who practice at Capital Health must meet certain educational and experience requirements; however, Capital Health is not responsible for specific care provided to you by that physician. If you wish to change your physician, ask to speak with a nurse manager.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Contact by Telephone, Cellular, and/or Electronic Communications: By signing this form you consent to the terms in this section. Capital Health conducts patient care quality reviews to ensure the continued highest quality of services. Patients may participate or be invited to participate in the surveys through the use of text messaging, phone call, automatic telephone dialing system, artificial, prerecorded voice messaging, or electronic mail. These communications may come from Capital Health or a third party vendor to the phone number or email address that the patients have provided. Patients are not required to provide a phone number or email address as a condition of receiving treatment and/or other healthcare service from Capital Health. Should you choose to opt out of receiving contact from Capital Health or its third party vendor, you understand that it is your responsibility to contact Capital Health Patient Experience Department at 1-609-394-6336 (RMC) or 1-609-303-4280 (Hopewell) with this information. Message and data rates may apply.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Treatment: I consent to be treated by/admitted to Capital Health under the care of my physician, and their associates, partners, assistants, and designees. I consent to any hospital care, which encompasses routine laboratory, diagnostic, or medical/surgical treatment advisable during treatment and or hospitalization. I agree to allow medical students, interns, and residents, under the supervision and direction of a physician to observe my treatment and review my medical record. I understand that no guarantees have been made to me about the outcome of this care. I acknowledge that Capital Health has the authority to dispose of specimens taken for laboratory and pathology examinations.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Interoperability – Admission, Discharge and Transfer Notifications

In accordance with the Interoperability and Patient Access final rule (CMS-9115-F) Capital Health is required to make Conditions of Participation (CoPs) for hospitals. CoPs require Capital Health sends electronic patient event notifications of patient's Admission, Discharge, and/or Transfer to another healthcare facility, or to another community provider or practitioner. Government regulations require Capital Health to notify your primary care physician, referring physician, or other community provider in the event that you are admitted, discharged, or transferred to another facility.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Acknowledgement of Privacy Notice: I acknowledge receipt of Capital Health Notice of Privacy Policy:

☐ **By checking this box, I confirm that I have received the Capital Health Notice of Privacy Practices. The act of checking this box shall have the same effect as signing my name.**

By signing below, I agree to be subject to all of the terms in this General and Financial Consent. I agree that any checked boxes shall have the effect of my written signature.

X _____ Relationship to Patient: _____ Date: _____Time: _____
(Signature of patient or patient representative)

Witness: _____ Date: _____ Time: _____

Patient Name: _____ DOB: _____ Date: _____

Living Will:

Do you have a Living Will and Durable Power of Attorney? **YES** **NO**

If **YES**, please furnish us with a copy for your medical chart or allow us to make a copy to attach to your chart. Thank you.

If **NO**, would you like more information regarding this subject? **YES** **NO**

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., Please indicate where we can leave a message:

CIRCLE YES OR NO

HOME NUMBER ~ YES / NO _____

CELL NUMBER ~ YES / NO _____

II. I AUTHORIZE THE FOLLWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I agree _____ to the above. Date Signed: _____
(Patient Signature)

Signing this form verifies all information is correct and /or has been updated.

capitalhealth

Medication History & Medication Benefits Consent

I give permission for Capital Health to obtain my current Medications and Medication History from the Surescripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at Capital Health.

Patient Signature: _____ Date: _____

capitalhealth
MEDICAL GROUP

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call your office. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a **24 hour** advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your appointment history as a "no-show".

Missed Appointment Fees

- Patients who fail to keep an appointment will be rescheduled once upon request: **No Charge**
- After a second and subsequent missed appointment: **$25 fee billed to your account**
- Third missed appointment: **Possible discharge from our practice**

Patient Name: _____

Patient's Signature: _____ Date: _____