Watermark Medical ARES Questionnaire ©

PRINT IN CAPITAL LETTERS - STAY WITHIN THE BOX All Fields Required-unless otherwise specified

Last Name | First Name | Middle Initial | Gender: Male ☐ Female ☐

Date of Birth Month | Day | Year **Weight** Pounds **Height** Feet | Inches **Neck Size** Inches

I.D. Number (optional)

Tally ARES Risk Points

Neck Size
+2 Male ≥16.5
+2 Female ≥15

Score ☐

COMPLETELY FILL IN ONE SQUARE FOR EACH QUESTION - ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Heart disease	Yes ☐	No ☐	Depression	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Sleep Apnea	Yes ☐	No ☐
Lung disease	Yes ☐	No ☐	Nasal oxygen use	Yes ☐	No ☐
Insomnia	Yes ☐	No ☐	Restless legs syndrome	Yes ☐	No ☐
Narcolepsy	Yes ☐	No ☐	Morning Headaches	Yes ☐	No ☐
Sleep Medication	Yes ☐	No ☐	Pain Medication e.g. vicodin, oxycontin	Yes ☐	No ☐

Co-morbidities
+1 for each Yes response

Score ☐

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. 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 tomark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

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

	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, inactive, in a public place (theater, meeting, etc)	☐	☐	☐	☐
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	☐	☐	☐	☐

Epworth Score
Total the values from all 8 questions.
If 11 or less Score = 0
If 12 or more Score = 2

Score ☐

Frequency (Check one for each question): Never **+0**, Rarely **+1** times/wk, Sometimes **+2** times/wk, Frequently **+3** times/wk, Almost Always **+4** times/wk.

On average in the past month, how often have you snored or been told that you snored?

Never +0 ☐ Rarely +1 ☐ Sometimes +2 ☐ Frequently +3 ☐ Almost always +4 ☐

Do you wake up choking or gasping?

Never +0 ☐ Rarely +1 ☐ Sometimes +2 ☐ Frequently +3 ☐ Almost always +4 ☐

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never +0 ☐ Rarely +1 ☐ Sometimes +2 ☐ Frequently +3 ☐ Almost always +4 ☐

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always ☐

Total points for the first three responses ☐

Point Total ☐

I have personally completed this questionnaire.
Signature

Date

Phone Number

Total all 4 boxes from the right side
If points total =3 or lower (no risk)
4 or 5 (low risk), 6 to 10
(high) and 11 or more (very high risk)

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Sleep Disorders Center

HOME SLEEP TEST CONSENT AND EQUIPMENT ACKNOWLEDGMENT

Patient Information

Last Name: _____ First Name: _____ DOB: ____/____/_____

Preferred Contact Number: _____ Home – Cell – Work (Circle one) Sex: M F

Credit Card Type: Visa – MC – American Express – Discover –Others_____

Notes: Your credit card will not be charged unless you fail to return the equipment to our practice. Note: There will be a 4% processing fee for all credit card transitions. (*In the event that the machine is not returned, you will be charged $200 per day for late fee*). (*A copy of the card will be asked to be put on file upon pick up of the equipment*).

Consent

I, _____ agree to have a Home Sleep Test (HST) performed on me as specified by my medical provider's order. The procedure involves the attachment of a belt and monitoring device that I will be responsible for using. I understand that the proper administration of my HST will be explained to me and that I will receive adequate written and visual education materials to properly administer the test. We ask that you acknowledge your receipt of this equipment, and that you agree to return the equipment after completion of the study. (*I acknowledge that failure to return the equipment provided to me will result in my credit card being charged for the late fee.*)

Acknowledgement of Receipt of Testing Equipment

I acknowledge receipt of Home Sleep Testing equipment and agree to use start the study on the date equipment is picked up and return the device and its parts as listed below, by the date noted below. Should I fail to return the equipment and all related components in the condition in which they were received, I agree to pay CMD Sleep the fee for replacing devices which have been lost, damaged or not returned, of up to $1000. The kit contains the following:

-Ares Unicorder -Respiratory Belt -USB Charger -User Guide -Travel Case

(To be completed by the office staff)
Equipment pick-up date: _____
Expected equipment return date: _____ *Return by 10:00 AM local time*

Release of Information and Patient Confidentiality

Comprehensive Medical Diagnostics, LLC (CMD Sleep) will provide a copy of the results of any procedure performed to the ordering physician. The undersigned further acknowledges that CMD Sleep is authorized to provide these results to other physicians and/or durable medical equipment companies as requested to complete prescriptions for equipment (ex: CPAP machine) that may be ordered as a result of the sleep study findings.

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process claims to insurance companies or their agencies. I ACKNOWLEDGE THAT IF I FAIL TO RETURN THE EQUIPMENT AS LISTED ABOVE, A LATE FEE MAY BE CHARGED TO MY CREDIT CARD. I permit a copy of this acknowledgement to be used in place of the original.

Signature: _____ Date: _____

Relationship to patient: _____ Representative Name (printed): _____

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Name:_____ Date of birth: ____/____/____ Gender: M F

Address:_____ City:_____State:_____ Zip code:_____
Home phone:_____ Work phone:_____
Cell phone: _____ Email: _____
Emergency phone:_____ Contact person:_____
Soc. Sec. Number:_____ Marital Status: M S W D
Spouse's name:_____ Spouse's date of birth:_____/_____/_____

Employment Information

Retired: Yes_____ No_____ Date Retired: _____/_____/_____
Employer Name :_____
Address:_____

Insurance information **Please fill in Completely**

Primary insurance name:_____
Insured Person's Name: _____ID#: _____ Group #:_____
Secondary insurance name:_____
Insured Person's Name:_____ID#: _____ Group #:_____

Referring Physician Information *(Physician that referred you for sleep study)*

Name: _____
Specialty: _____
Address: _____
City: _____ State:_____ Zipcode:_____
Office Phone #:_____ Office fax #:_____

Primary Care Physician

Name: _____
Address _____
City: _____ State:_____ Zipcode:_____
Office Phone #:_____ Office fax #:_____

Please read and sign

I authorize the release of any medical information necessary to process this claim. I also authorize the attending physician to release information concerning my exam and treatment . I consent to treatment for my sleep study at CMD Sleep Center and I am also aware that I am responsible for payments of copays, deductibles and any other fees that my insurance will not cover.

Signature: _____ **Date:** _____/_____/_____

Signature: _____ **Date:** _____/_____/_____
If you are the guardian or P.O. A. sign here

Authorization #: Global: ICD 10 codes:

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Billing and Insurance Acknowledgement

Please review and initial that you acknowledge and agree to the following statements.

Medicare Acknowledgement:
I request that payment of authorized Medicare benefits be made either to me or to [Comprehensive Medical Diagnostics, LLC] for any services furnished to me. I authorize any holder of medical information about me to be release to "The Centers for Medicare & Medicaid Services", and its agents any information needed to determine these or the benefits payable for related services. I understand that I will be responsible for any deductible, coinsurance, and non-covered expenses. _____ (Initials)

Commercial Insurance Acknowledgement:
I request that payment of authorized Health Insurance benefits be made either to me or to [Comprehensive Medical Diagnostics, LLC] for any services furnished to me. I understand that I will be responsible for any deductible, coinsurance, and non-covered expenses. Any payments made to me by my insurance company for services rendered at [Comprehensive Medical Diagnostic, LLC] will be mailed to the sleep lab (address on header). _____ (Initials)

I authorize [Comprehensive Medical Diagnostics, LLC] to release all medical information necessary for processing insurance claims to the insurers on file. I agree these provisions will be in effect until otherwise revoked by me.
_____ (Initials)

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other healthcare provider, including hospitals, diagnostic centers, and etc. I specifically authorize such healthcare providers to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other reports or information regarding my physical condition. _____ (Initials)

Acknowledgement for SELF-PAY:
You have requested that this service to be self-pay because (initial one):
____You have no health insurance.
____You have health insurance, but you do not want your insurance billed and instead want to pay out of pocket.
____ Other (Please Explain): _____

NO SHOW
_____ I understand that sleep lab may charge a $200 "no show" fee in the event that I do not call with at least 24 hours' notice to cancel or reschedule an appointment.

By signing below, I acknowledge that I have read and understand the above information. I confirm that I am the patient, or the patient's duly authorized representative.

Signature of Patient or Legal Representative: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

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Pediatric Sleep Questionnaire

Name:	DOB:	Age:	Date:
What does your child like to be called?		Male	Female
Home Ph.#	Work Ph.#	Cell Ph.#	
Referring MD:	*Primary MD:*		
Height	Weight		

PRESENT HISTORY/SLEEP HISTORY:

What are your main concerns regarding your child's health today?

Does your child snore?	YES	NO	How Often?
Only with a cold/infection			
Does your child sleep restlessly/flip and flop at night?		YES	NO
Are you concerned about your child's breathing when asleep?		YES	NO
Is your child a mouth-breather?	*Usually*	*Occasionally*	*Rarely*
If toilet trained, does your child wet the bed?	NO	Occasionally	Frequently
Does your child seem tired during the day?		YES	NO
Does your child seem hyperactive to you?		YES	NO
Do you have concerns about ADD or ADHD in your child?		YES	NO
Does your child have frequent nasal drainage/sinus infection?		YES	NO
Does your child have frequent sore throats?		YES	NO
Does your child have frequent ear infections?		YES	NO
Has your child had Ear tube surgery?		YES	NO
Do you have concerns about your child's growth or weight?		YES	NO
If yes above, describe.			
Has your child had surgery on the tonsils and/or adenoids?	Date of surgery:		NO
Circle what was removed		Tonsils	Adenoids

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SLEEP SCHEDULE:

	Weekday	Weekend
What time is Bed Time?		
What time do they wake-up?		
What is your child's bedtime routine?		
Does your child have difficulty going to sleep?	YES	NO
Does your child wake up frequently at night?	YES	NO
Number of awakenings/night		
Does your child kick at night?	YES	NO
Complain of leg pain?	YES	NO
Is your child difficult to awaken in the morning?	YES	NO

PAST MEDICAL HISTORY / SOCIAL HISTORY:

Was pregnancy and delivery of your child normal?	YES	NO
Please list any other medical problems/history related to your child:		
Please estimate the number of caffeinated drinks your child has daily		
Time of day consumed		
Does your child have a history of psychological/psychiatric problems?	YES	NO
Please list any details about this that you feel will be helpful in the care of your child:		
Present grade in school:		
How do you feel your child is doing if in school?		
In your child's bedroom, is there a TV?	YES	NO
Is there a computer?	YES	NO
Does your child share a bedroom?	YES	NO
If yes, age of roommate		

FAMILY HISTORY:

Is there a family history of any sleep problems? List relationship to child and type of problem:

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MEDICATIONS:

List all medications (OTC, minerals, herbals, supplements, weight loss aids).

Medication Name	Dose	Freq	Usual Time of Last Dose	Reason	Ordering MD

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

HOW LONG HAVE YOU HAD THIS PAIN? ___YEARS ___MONTHS ___WEEKS

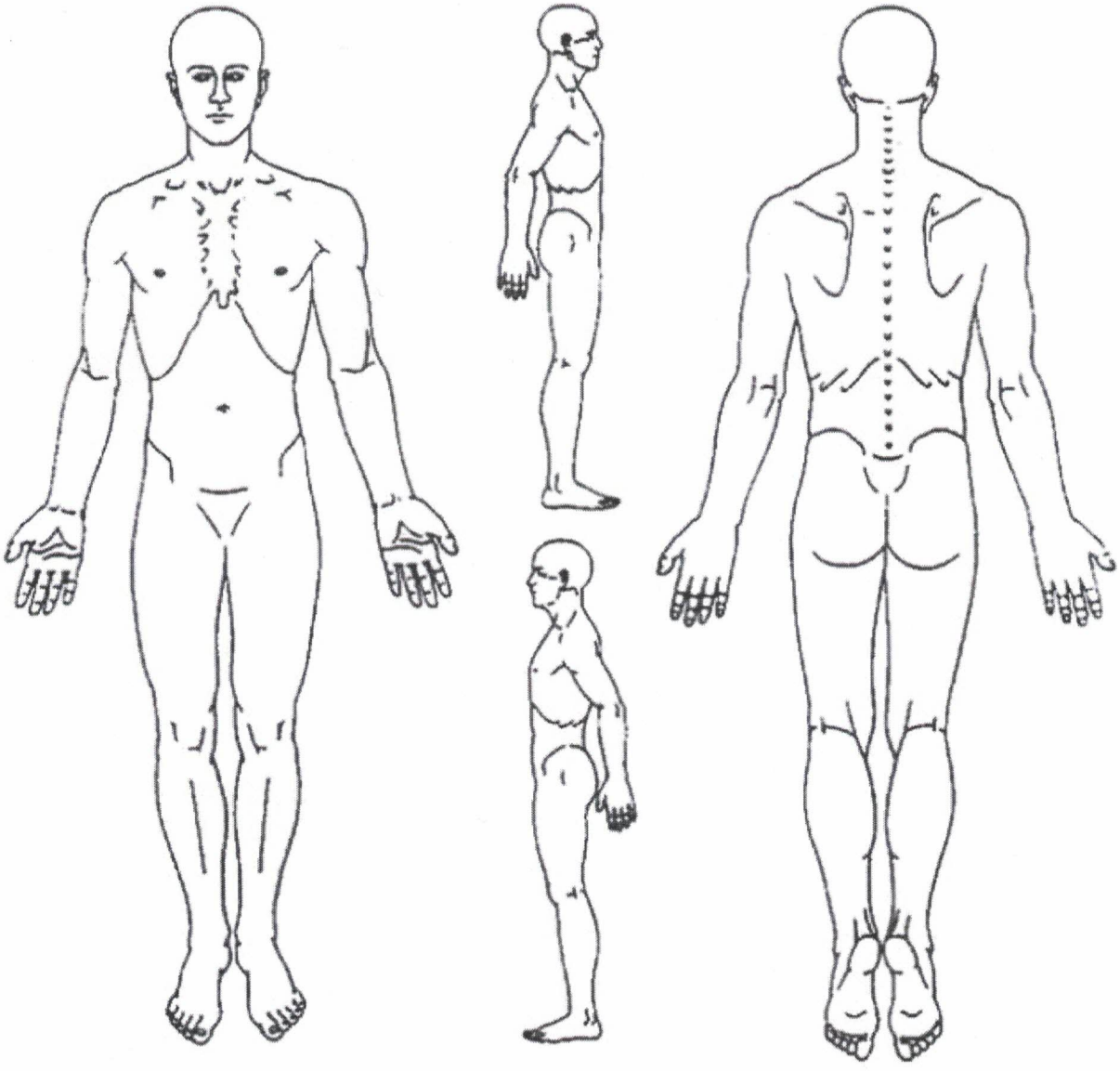
IS THIS YOUR FIRST EPISODE OF THIS PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:

A=ACHE	B=BURNING	N=NUMBNESS
P=PINS & NEEDLES	S=STABBING	O=OTHER



OVER PLEASE

For Doctor's Use:

Chief compliant (other than neck or low back pain): _____

_____

(For neck conditions use the Neck Pain Disability Index Questionnaire; for lower back conditions use the Roland-Morris or the Oswestry Low Back Pain Disability Questionnaire.)

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*This form is to be completed by the patient's parent, guardian or caretaker.

Bed Partner Questionnaire

(To be completed by pt's bed partner)

Patient Name: _____ Date: _____

Your Name: _____ Relationship: _____

I have observed this person sleep (circle one): Never Once Twice Often Every Night

Check any of the following that you have observed this person doing while asleep. **Check** those that you consider severe problems.

__Light Snorer
__Moderate Snorer
__Loud Snorer
__Twitching or Kicking of Legs
__Choking
__Sitting up in bed Not Awake
__Head Rocking or Banging
__Biting Tongue
__Crying out
__Becoming very rigid and shaking
__Apparently sleeping even if he/she says otherwise
__Occasional Loud Snorts
__Grinding Teeth
__Pauses in Breathing
__Sleep Talking
__Bed-wetting
__Awakening with Pain
__Getting out of bed Not Awake

Other_____

If this person snores, what makes it worse?
__Sleeping on his/her back
__Sleeping on his/her side
__Fatigue
__Alcohol

Please describe the behaviors checked in more detail. Describe the time when it occurs, how often it occurs during the night, and whether it occurs every night.

_____
_____
_____
_____
_____

Has this person fallen asleep during normal daytime activities or in dangerous situations? Yes/No? If yes, please explain: _____
_____
_____
_____
_____

Does this person use sleeping pills? Yes/No? What kind? _____
How often?_____
Does this person drink alcohol? Yes/No?
Please estimate the per (weeknight/weekend) use of: ___/___12 oz. Bottle/can/tap beer. ___/___6-8 oz. Glasses of wine ___/___ 1-1/2 oz. bottle/cap/tap liquor.
Please estimate how much alcohol this person consumes in the 3 hours before bed:
_____
If this person uses recreational drugs, please describe both the types and frequency of usage:
_____