SLEEP DISORDERS INSTITUTE

*****PLEASE CALL THE DAY OF YOUR APPOINTMENT TO CONFIRM*****

Welcome to the Sleep Disorders Institute, an accredited health care facility that offers state-of-the-art diagnostic and treatment services to adults and children who suffer from disorders of sleep and wakefulness. The staff of the Institute is composed of an interdisciplinary team of expert physicians, sleep physiologists, and technologists who are dedicated to providing you with high quality health care.

Enclosed is the information you will need for your first appointment at the Institute. This packet includes a Patient Guide, and a Sleep Disorders Questionnaire that you should -complete and bring with you to your appointment.

Our Manhattan center is located on 330 W 58th Street, Suite 509. Directions are included in the Patient Guide, and you may find additional travel information at www.SLEEPNY.com

If you have health insurance coverage that allows benefits to be paid directly to the Sleep Disorders Institute, we will bill your provider directly. You will only be required to pay the portion of your bill that is not covered by your provider. **If you are not covered by a health insurance plan**, or the Sleep Disorders Institute cannot receive direct payment from your insurance company, **payment in full must be made at the time of service.** Payments may be made by cash, personal check, Visa, MasterCard, American Express or the Discover card.

If you must cancel/reschedule an appointment, we ask that you contact us 24 hours prior to your appointment. Please call to confirm your appointment on the day of your visit. If you have a weekend appointment, please call the Thursday before your appointment.

PLEASE NOTE THAT WE MUST CHARGE WHEN THERE IS A LATE CANCELLATION OR "NO SHOW."

We understand that people forget appointments or have emergencies that prevent them from keeping their appointments; however, once an appointment slot is reserved it is your slot. We do not double book, and expect to provide you with prompt, on-time service. If you are unable to keep your appointment, we require 24-hours notice of cancellation. If you are late we will do our best to accommodate you on the day of your visit, but this may require you to wait for the next open slot.

A MISSED CONSULTATION APPOINTMENT WILL BE BILLED AT $100, AND A MISSED APPOINTMENT FOR OVERNIGHT TESTING WILL BE BILLED AT $150. THESE CHARGES ARE NOT RE-IMBURSABLE BY INSURANCE.

If you have any questions about your visit to the Sleep Disorders Institute please call the office at (212) 994-5100. On behalf of the staff at the Institute, we look forward to providing you with health care services.

INSURANCE REFERRALS MAY BE REQUIRED
CONTACT OUR OFFICE TO CONFIRM

For daytime appointments you must arrive on time with your completed paperwork or you risk forfeiting your appointment.

SLEEP DISORDERS INSTITUTE

330 W 58th Street, Suite 509,
New York, NY 10019
(212)994-5100, Fax (212)994-5101

PATIENT INFORMATION FOR OVERNIGHT AND DAYTIME LABORATORY STUDIES

You have been scheduled for polysomnography. Note that your appointment may be cancelled and/or rescheduled if we are unable to obtain pre-certification from your insurance carrier, or for other reasons. Therefore, you are advised to contact the Institute on the day of your testing to confirm your appointment. Weekend patients must call prior to 5 PM on Friday to confirm. You have been scheduled for the following test(s):

- ❑ **Routine Polysomnography:** Routine polysomnography is ordered to confirm or rule out the diagnosis of sleep apnea, narcolepsy, insomnia, and most other sleep disorders. This type of recording typically consists of 15 or 16 channels of polygraphic recording. The variables measured include two channels of electrooculographic (EOG) activity, three to four channels of electroencephalographic (EEG) activity, one channel of chin electromyographic (EMG) activity, one channel of electrocardiographic (EKG) activity, one channel of nasal/oral air flow, one channel of abdominal respiratory effort, one channel of oxygen saturation as measured by pulse oximetry, and one channel of snoring sounds. Video and audiotape are continuously recorded and measures of body position are obtained.

- ❑ **Multiple Sleep Latency Test (MSLT):** The MSLT routinely follows nocturnal polysomnography. The MSLT provides the patient with four or five scheduled opportunities to nap during the day. This is a routine test in the evaluation of daytime sleepiness. The mean latency to sleep onset for all naps is calculated as a measure of daytime sleepiness. The MSLT can be important in determining the severity of sleep apnea or your response to treatment. Detection of rapid-eye-movement (REM) sleep episodes on the MSLT may be required for the diagnosis of narcolepsy.

- ❑ **Nocturnal Polysomnography with CPAP Titration:** May be ordered for patients with sleep related breathing disorders confirmed by nocturnal polysomnography. Consists of all measures included in routine nocturnal polysomnography as well as the application of nasal continuous positive airway pressure (CPAP) or intermittent positive airway pressure (BiPAP). Nasal CPAP and BiPAP pressures are adjusted throughout the night to determine the appropriate pressure(s) to be prescribed in treatment.

- ❑ **Split-Night Polysomnography:** Split-night polysomnography combines essential elements of Routine Polysomnography (see above) and Nocturnal Polysomnography with Nasal CPAP Titration (see above). Split-night polysomnography typically is ordered under special circumstances in order to obtain diagnostic data and treatment data in one night of recording.

- ❑ **Maintenance of Wakefulness Test (MWT):** The MWT is a test that is used to determine an individual's ability to remain awake when placed in an environment that is conducive to sleep. The procedure is similar to the MSLT (see above) in that four or five test sessions occur throughout the day. However, each test challenges the individual's ability to remain awake while laying supine in a darkened room. The MWT may be used to determine response to treatment, and may provide documentation of a person's ability to remain awake in critical situations.

- ❑ **Specialized Polysomnographic Procedure:** Includes transcutaneous CO_2 monitoring, EEG studies to rule out seizure disorders, application of positive pressure ventilation or negative pressure ventilation for the treatment of some sleep-related breathing disorders, or other specialized polysomnographic procedures.

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ABOUT THE TESTS

The test(s) for which you have been scheduled will include measures of brain activity, muscle activity, breathing, and heart rate. Depending on the nature of your study, other measures may also be obtained. All recordings are performed in one of the Institute's private patient rooms, which are comfortably furnished to recreate a home bedroom environment.

All of the tests performed are painless. Recording devices are placed only on the surface of the skin. Small electrodes will be applied to the surface of your scalp, face, chest and lower legs for recording of sleep patterns. Airflow, heart rate, chest movement, abdominal movement, and oxygen level will also be monitored. Some people, especially those with sensitive skin, may experience minor skin irritation from the paste and/or cleansing solution used to apply and remove the electrodes.

At times, it may be necessary for the technician to move the blanket/covers while you sleep to assure clear visibility of limb and/or chest movements. Your sleep will be videotaped to aid in your diagnosis. You may also be photographed while awake so that the physician can have documentation of your body size and shape, and the structure of your upper airway.

The recording equipment used to measure sleep is very sensitive and can be damaged if not handled properly. We ask that you allow the technical staff to apply and remove all recording equipment. Patients are responsible for breakage due to mishandling. Insurance does not cover these costs.

Due to our sanitary precaution policy, all patients are required to change into scrubs when they arrive and place their personal items into a plastic bag. The Sleep Disorders Institute will provide you with a set of scrubs to wear to sleep and a plastic bag for your personal items. The scrubs must be returned following your test(s), or you will be charged for the purchase of these items.

WHAT TO BRING

Pack a small bag with all of the items you will need for an overnight stay away from home. Keep in mind that you will be monitored all night by both male and female technicians. Please pack appropriate underclothing so that you will feel comfortable in the presence of technicians during the sleep study. Do not bring valuables with you.

We supply soap, shampoo, towels, a blow drier, bed linens, and pillows. In the morning it will be necessary to shower and wash your hair to facilitate the removal of the sensor paste from your hair and skin.

Pack your prescription medication. The Institute does not stock or dispense any prescription or nonprescription medication.

Those undergoing a **Multiple Sleep Latency Test or Maintenance of Wakefulness test.** You will be permitted to walk around the Institute's public area and the recording sensors will remain attached throughout the day. You may want to bring a laptop books, magazines, etc. to occupy yourself between test periods. The Institute does have free Wi-Fi available. There is a public television area as well. Use of the Institute’s office telephones is prohibited.

MEALS

The Institute does NOT provide meal service. Patients scheduled for Multiple Sleep Latency Tests will be at the Institute until approximately 5:00 PM. They are encouraged to bring their own food for breakfast and lunch. Caffeinated beverages (coffee, tea and soda) are to be avoided. A refrigerator and microwave oven are available for use. Other options include ordering from a nearby restaurant, deli or convenience store. For those patients opting to order in food, the Institute has selected menus from local restaurants. Patients are responsible for all food charges and tips to the restaurant's delivery personnel.

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PRIOR TO YOUR SLEEP STUDY

Unless otherwise directed by a physician from the Sleep Disorders Institute, do not alter your sleep schedule during the week prior to your study. This helps to ensure that your night in the laboratory is representative of one of your typical nights of sleep.

Upon arriving at the sleep laboratory you will be asked to record the medications you take, your meal times, and your sleep schedule for the night prior to the study. In addition you will be asked to sign a consent form and authorization to release medical records form if you want copies of your study results sent to your doctor, or if you want a copy for yourself.

ON THE SCHEDULED DAY OF YOUR STUDY

- ✓ **DO** make sure your skin and hair are clean before you arrive at the laboratory. This improves the ability of our technical staff to comfortably apply and remove recording electrodes. Shampoo and **DO NOT** apply oil, gel or conditioner to your hair.

- ✓ **DO NOT** use alcohol or non-prescription drugs (vitamins, supplements, aspirin etc) on the day of your study. Consult with your Sleep Disorders Institute physician regarding the use of prescription medication on the day of your study.

- ✓ **DO NOT** drink coffee or consume other caffeinated food or beverages (soda or tea) after 12 noon on the day of your study.

- ✓ **DO NOT** eat after 7:00 PM on the evening of your study.

- ✓ If you develop a cold or respiratory infection, **DO** contact the Institute to see if your study should be rescheduled. Women who have severe premenstrual symptoms should consider rescheduling if these symptoms disturb their sleep.

- ✓ **DO a**rrive at the Institute at your scheduled time. If you **expect to be delayed**, **please contact the Institute** so that a member of our staff can advise you or assist in rescheduling you. Call our 212/994-5100 before 5 PM or **call 212/994-4565 after 6:00 PM** if you expect to be delayed. There is a $100 fee for late cancellations and missed appointments, which is not covered by your health insurance plan.
- ✓ Family members, friends, and/or companions may only accompany patients to the reception area on the night of the scheduled testing. Unless the patient is a minor, or there is medical necessity, **under no circumstances will anyone be permitted entry to the testing area.** Visitors must leave once overnight or daytime nap testing has begun.

PAYMENT

Your insurance co-payment is due on the day of testing.

Payment may be made in cash, or by personal check, debit or credit card (American Express Visa, MasterCard, or Discover Card).

TEST RESULTS

Information recorded during your sleep study is scored and interpreted by a sleep specialist. It is presented to the Institute's multidisciplinary team of physicians at the Institute's daily case conference. You will be contacted to discuss your test results within 10 - 15 business days following your overnight test.

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REPORT REQUESTS

A final, comprehensive written report of your test results will be sent to those physicians whom you designated on the Authorization to Release Medical Records form you are asked to sign at the time of your study. The Institute will send complimentary copies of your study to two physicians you identify. You must provide us with the full name, address, and telephone number of all recipients. Recipients may include your referring physician, primary care physician, or health care providers. Requests for more than 2 persons will incur a $10.00 fee for each additional report. **Please allow a minimum of 7-10 business days from the date your study has been brought to Case Conference before the test results are available.**

FOLLOW-UP APPOINTMENTS

We report your test results to you by telephone, and we always recommend that you follow-up with your referring doctor. If your case requires extensive involvement by a Sleep Disorders Institute physician, you will be asked to be seen for a follow-up visit at the Institute. We do not conduct visits by telephone. Your insurance carrier will not cover the call of telephone consults. Extended calls (more than 10 minutes) will be billed at our normal office rates.

QUESTIONS

If you have any questions regarding your laboratory studies, please feel free to contact the Institute at (212) 994-5100. We welcome the opportunity to provide you with health care services.

SLEEP DISORDERS INSTITUTE

Sleep Disorders Institute Registration Form

330 W 58th Street, Suite 509,
New York, NY 10019
Telephone: (212) 994-5100

Date: _____ Patient: _____
Last Name First Name Middle Initial

Email: _____ Home Phone: _____ Mobile Phone: _____

Responsible Party (if a minor): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Date of Birth: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Spouse (or responsible party) Name: _____ Date of Birth:_____

Business Name and Address: _____

Occupation: _____ Business Phone: _____

Who is responsible for this account? _____ Relationship to patient: _____

Social Security #: _____ Spouse's Social Security #: _____

Do you have Medical Insurance? ☐ No ☐ Yes → If yes,

Name of Primary Insurer: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Name of Secondary Insurer (if any): _____

Contract #: _____ Group #: _____ Subscriber #: _____

☐ Medicare ☐ Medicaid Claim ID #: _____

If Welfare, your number: _____ County of: _____

In case of emergency, who should be notified? _____ Phone: _____

How did you learn of our practice? _____

Assignment and Release

I, the undersigned, have insurance coverage with _____
(Name of Insurance Company)
and assign directly to **Sleep Disorders Institute** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges due for services that I receive, including all amounts not paid by insurance, and I will submit payment to the Sleep Disorders Institute. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

SLEEP DISORDERS INSTITUTE

330 W 58th Street, Suite 509,
New York, NY 10019
(212)994-5100, Fax (212)994-5101

INDIVIDUAL AUTHORIZATION

Patient Name: _____ **ID Number:** _____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purpose(s) described below. The form provides that authorization and helps us make sure that you are properly informed of how this information will be use d or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

A staff member of our office must fully answer any questions you may have regarding this form. DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? Health information about you may be disclosed by a physician, nurse or member of our office's staff.

Who will use and/or receive the information? The person(s) or class of persons to whom you authorize our office to disclose your health information are (please also provide us with the address and contact information of those person(s) or class of persons if you are asking us to send medical records or health information out of our office):

_____
_____
_____
_____

What information will be used or disclosed? The appropriate boxes should be checked below, and the descriptions should be in sufficient detail so that our office staff can understand what information may be used or disclosed.

☐ All medical information that our office has about you

☐ The following specific information:

_____
_____
_____
_____

☐ The following HIV-related information (which is any information indicating that you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have been potentially exposed to HIN):

SLEEP DISORDERS INSTITUTE

_____
_____
_____
_____

What is the purpose of the use or disclosure? The appropriate boxes should be checked below, and the descriptions should be in sufficient detail so that our office staff can understand the purpose(s) for which health information may be used of disclosed.

☐ The health information you have indicated to the person(s) you have indicated

☐ Other purpose:

_____
_____
_____
_____

When will this authorization expire? The date or event that will trigger the expiration of this authorization is:

_____
_____

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. You should note that when your protected health information is disclosed to people or entities that are not required to abide by federal or state medical privacy laws, those people entities may re-disclose your information to others and use your information without being subject to penalties under those laws.

If you are authorizing the release of HIV-related information, you should be aware that the recipients(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Right s at (212) 306-7450. These agencies are responsible for protecting your rights.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that our practice has already taken action based upon your authorization. To revoke this authorization, please write to Elysa Feigenbaum.

SLEEP DISORDERS INSTITUTE

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____
Signature of Patient or Patient's Personal Representative

_____
Print Name of Patient or Patient's Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

CONTACT INFORMATION

The contact information of the patient or personal representative who signs this form should be filled in below.

Address:
_____
_____
_____
_____

Telephone:
_____ (daytime)
_____ (evening)

Email Address (optional):
_____

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

SLEEP DISORDERS INSTITUTE

330 W 58th Street, Suite 509,
New York, NY 10019

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to protect the privacy and health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our physician private practice ("practice" or "office") and its staff. A copy of our current notice will always be posted in our reception area. You will also be able to obtain your own copy by calling our office at 212-994-5100 or by asking for one at the time of your next visit.

If you have any questions about this notice or would like further information, please contact our Privacy Officer at 212-994-5100.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing you with health care. Some examples of protected health information are:

- information indicating that you are a patient of our practice or receiving treatment or other health-related services from us;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future (such as an operation or a CT scan); or
- information about your health care benefits under an insurance plan (such as whether a prescription is covered);

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); or
- other types of information that may identify who you are.

REQUIRED PERMISSIONS TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct our business operations. This general written consent will be obtained the first time we provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

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We will generally obtain your written authorization before using your health information or sharing it with others outside of our practice. You may also ask that we transfer your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that

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written authorization at any time, except to the extent that we have already relied upon it or taken action to do what you asked us to do. To revoke a written authorization, please write to our Privacy Officer Elysa Feigenbaum.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment, Payment And Business Operations

With your general written consent, we may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payor. Below are further examples of how your information may be used and disclosed for these purposes.

Treatment. The doctors, nurses and other staff of our practice may share your health information with a doctor outside of our practice to determine how best to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

Payment. We may use your health information or share it with others so that we can get payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you, or to determine whether it will cover your treatment. We might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your treatment, such as admitting you to a hospital for a particular type of surgery. Finally, we may share your information with other health care providers who have treated you so that they also can have accurate information to seek payment from your health insurance company or managed care plan.

Business Operations. We may use your health information or share it with others in order to conduct our office's business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you. Finally, we may share your health information with other health care providers and with your health insurance company or managed care plan for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

Appointment Reminders, Treatment Alternatives, Benefits And Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

Fundraising. To help raise money in support of the business operations of hospitals and medical schools with which our physicians are affiliated, we may use demographic information about you, including information about your age, gender and where you live or work, and the dates that you received treatment. You therefore may receive fundraising appeals from the doctors at our office on behalf of the hospitals or medical schools with which they are affiliated.

Business Associates. We may disclose your health information to our contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain information with an accounting firm or law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health

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information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

We can do all of these things if you have signed a general written consent form. Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent. You may revoke your general written consent at any time, except to the extent that we have already relied on it. For example if we provide you with treatment before you revoke your general written consent, we may still share your health information with your insurance company in order to obtain payment for that treatment. To revoke your general written consent, please write to Elysa Feigenbaum at 212-994-5100.

2. Emergencies Or Public Need

We may use your health information, and share it with others, in order to treat you in an emergency or to meet important public needs. We will not be required to obtain your general written consent before using or disclosing your information for these reasons. We will, however, obtain your written authorization for, or provide you with an opportunity to object to, the use and disclosure of your health information in these situations when state law specifically requires that we do so.

Emergencies. We may use or disclose your health information in order to treat you, to obtain payment for that treatment, and to conduct our business operations if you need emergency treatment or if we are required by law to treat you but are unable to obtain your general written consent. If this happens, we will try to obtain your general written consent as soon as we reasonably can after we treat you.

Communication Barriers. We may use and disclose your health information in order to treat you, to obtain payment for that treatment, and to conduct our business operations if we are unable to obtain your general written consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

As Required By Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so.

Victims Of Abuse, Neglect Or Domestic Violence. We may release your health information to a public authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations and inspections of this office and its staff. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair And Recall. We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous

products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits And Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

To Avert A Serious And Imminent Threat To Health Or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security And Intelligence Activities Or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military And Veterans. If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military missions. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners, And Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Organ And Tissue Donation. In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information for research without your written authorization if we obtain approval

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through a special process to ensure that research without your written authorization poses minimal risk to your privacy.

3. Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment may see, or overhear discussion of, your health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.

1. Right To Inspect And Copy Records

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to Elysa Feigenbaum. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is $0.75 per page and must generally be paid before or at the time we give the copies to you.

We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days if the information if located at our offices, and within 60 days if it is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the timeframe above to explain the reason for the delay and when you can expect to have a final answer to your request.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

2. Right To Amend Records

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please write to Elysa Feigenbaum. Your request should include the reason(s) why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in

your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. Right To An Accounting Of Disclosures

After April 14, 2003, you have a right to request an "accounting of disclosures" which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice of Privacy Practices. An accounting of disclosures does not describe the ways that your health information has been shared between health care providers at our office or with other health care providers outside our practice, as long as all other protections described in this Notice of Privacy Practices have been followed (such as obtaining the required approvals before sharing your health information with our doctors for research purposes).

An accounting of disclosures also does not include information about the following disclosures:

- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);
- Disclosures for purposes of research, public health or our business operation of limited portions of your health information that do not directly identify you;
- Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers; and
- Disclosures made before April 14, 2003.

To request an accounting of disclosures, please write to Elysa Feigenbaum. Your request must state a time period within the past six years (but after April 14, 2003) for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2004 and January 1, 2005. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare, cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

4. Right To Request Additional Privacy Protections

You have the right to request that we further restrict the way we use and disclose your health information to treat your conditions, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care or

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payment for your care. For example, you could request that we not disclose information about a surgery you had. To request restrictions, please write to Elysa Feigenbaum. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

5. Right To Request Confidential Communications

You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work. To request more confidential communications, please write to Elysa Feigenbaum. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests. Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location.

6. Right To Have Someone Act On Your Behalf

You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

7. Right To Obtain A Copy Of Notices

If this notice is provided electronically, you have the right to a paper copy of this notice, which you may request at any time. To do so, please call our office at 212-994-5100. You may also obtain a copy of this notice by requesting a copy at your next visit. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. We will post any revised notice in our office reception area. You will also be able to obtain your own copy of the revised notice. The effective date of the notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the notice that is currently in effect.

8. Right To File A Complaint

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer Elysa Feigenbaum. No one will retaliate or take action against you for filing a complaint.

9. How To Learn About Special Protections For HIV, Alcohol and Substance Abuse, Mental Health, And Genetic Information

Special privacy protections apply to HIV/AIDS-related information, mental health information and psychotherapy notes. Some parts of this general Notice of Privacy Practices may not apply to these types of information. To request a Notice of Privacy Policy Practices that pertains to those types of health information, please contact our Privacy Officer, Elysa Feigenbaum.

SLEEP DISORDERS INSTITUTE

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ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment of services given to me, and for the business operations of this practice, its physicians , and staff.

_____

Signature of Patient or Patient's Personal Representative

_____

Print Name of Patient or Patient's Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

SLEEP DISORDERS INSTITUTE

330 W 58th Street, Suite 509,
New York, New York 10019
TEL: 212-994-5100 FAX: 212-994-5101

SLEEP DISORDERS INVENTORY

Stephen Lund, M.D., Joseph Ghassibi, M.D, Kathleen Rice, Ph.D., & Jon Freeman, Ph.D.

Instructions: Your responses to this questionnaire will offer your doctors a comprehensive overview of your sleep and sleep problems. In order to complete the questionnaire, you must respond to several "fill-in-the-blank" and "forced-choice" questions. Please answer all questions to the best of your ability, leaving no forced-choice item unanswered. Expect that the questionnaire will take you 15 to 20 minutes to complete. Follow the instructions on the last page to submit the questionnaire to your doctor or to Sleep Disorder Institute for review.

IDENTIFYING INFORMATION

Today's Date ___/___/___

Patient's Name _____
Last First Middle

Address _____

City _____ State _____ Zip code _____

Home phone ( ) _____ Work phone ( ) _____

Cellular phone ( ) _____ E-mail _____

Age _____ D.O.B. ___/___/___ Sex M F Marital Status (circle) S M D

Height _____ Weight _____ Lbs. Neck Size _____ inches.

Your occupation: _____

Your primary care physician:

_____ ( )
Name Address Telephone

Specialist who referred you to the Sleep Disorders Institute (if applicable):

_____ ( )
Name Address Telephone

Your referring doctor's area of specialty: _____

Place and date(s) of prior evaluation(s) for sleep disorders (if any):

_____ Date ___/___/___
Clinic or Hospital

_____ Date ___/___/___
Clinic or Hospital

OVERVIEW OF SLEEP PROBLEMS

1. Why are you seeking treatment at this time?

_____

_____

_____

_____

SLEEP ENVIRONMENT

2. Is there any aspect of your sleep environment that seems to contribute to your sleep problem? ..... Yes No

3. Are you bothered by the lighting conditions of your bedroom during sleep? ..... Yes No

4. Is your bedroom too hot or too cold during sleep? ..... Yes No

5. Is your bedroom too humid or too dry? ..... Yes No

6. Are you bothered by noise during sleep? ..... Yes No

7. Is your bed or bedding uncomfortable? ..... Yes No

8. Do you sleep with anyone else in the same room or the same bed? ..... Yes No

   If yes, are you bothered by your roommate's or bed partner's snoring or movements during sleep? ..... Yes No

   If yes, do you sleep in the same room or same bed with your children? ..... Yes No

9. Do you sleep in the same bed with a pet? ..... Yes No

SLEEP HABITS

10. What is your usual bedtime (the time your get into bed)? ..... _____ AM / PM

11. What is your usual rise time (the time you get out of bed)? ..... _____ AM / PM

12. Does your bedtime and rise time fluctuate from day to day? ..... Yes No

13. Do you change your bedtime and rise time on the weekends or on days that you do not work? ..... _____ AM / PM

    If yes, what is your usual bedtime on weekends or non-work days? ..... _____ AM / PM

    If yes, what is your usual rise time on weekends or non-work days? ..... _____ AM / PM

14. How long does it usually take you to fall asleep after you get into bed? ..... _____ mins

15. How many times do you usually awaken during the sleep period? ..... _____ times

16. What is the average duration of your awakenings? ..... _____ mins

17. On average, how long would you say you actually are asleep each night? ..... ____hrs ____mins

18. Do you have a regular, nightly routine that you follow every night before getting into bed? ..... Yes No

    If yes, what do you usually do? _____

    _____

19. Do you read, watch television, or engage in other activities while in bed before sleep onset? ..... Yes No

20. Do you usually eat before getting into bed, or while in bed before sleep onset? ..... Yes No

21. Do you tend to "watch the clock" before or during your sleep period? ..... Yes No

DAYTIME FUNCTIONING

22. Do you usually feel sluggish, sleepy, or fatigued upon awakening in the morning? ..... Yes No

23. Do you usually feel fatigued throughout the day? ..... Yes No

24. Are you bothered by low mood, irritability, or anxiety during the day? ..... Yes No

25. Are you bothered by problems with attention, concentration, or memory during the day? ..... Yes No

26. Do you find it hard to persist at things you are doing, even simple things? ..... Yes No

27. Do you have difficulty functioning in social situations due to fatigue? ..... Yes No

28 Do you have difficulty functioning at work due to fatigue? ..... Yes No

29. Are you usually bothered by sleepiness during the day? ..... Yes No

30. Do you feel that you've lost motivation to do things, or that you've lost interest or pleasure in activities that you used to enjoy? ..... Yes No

31. Has your sex drive (libido) diminished? ..... Yes No

32. Have you been eating less than usual, or have you recently lost weight? ..... Yes No

33. Have you been eating more than usual, or have you recently gained weight? ..... Yes No

34. Do you tend to fall asleep in sedentary situations (for example, while watching television, working at a computer, in meetings)? ..... Yes No

35. Do you fall asleep when in a warm room? ..... Yes No

36. Do you tend to fall asleep at inappropriate times? ..... Yes No

If yes, please give an example: _____

37. Has your sleepiness or falling asleep ever put you or someone else in danger? ..... Yes No

38. Have you had a motor vehicle accident due to sleepiness or fatigue? ..... Yes No

39. Do you feel disabled by daytime sleepiness or fatigue? ..... Yes No

40. Do you usually nap during the day? ..... Yes No

If Yes:

How long do you usually nap? _____ minutes

What time of day do you usually nap? Morning / Afternoon / Evening

How many naps do you usually take per day? _____

How many naps do you usually take per week? _____

DIFFICULTY FALLING ASLEEP AND STAYING ASLEEP

41. Do you usually have difficulty falling asleep at the beginning of the sleep period? ..... Yes No
42. Are you bothered by awakenings that occur during the night (after you've fallen asleep)? ..... Yes No
43. Do you wake up too early and find that you can't return to sleep? ..... Yes No
44. If you answered yes to any of the above, are you bothered by the problem? ..... Yes No
45. Does difficulty falling asleep or staying asleep interfere with your daytime functioning? ..... Yes No

SLEEP QUALITY

46. Are you bothered by restless or fitful sleep? ..... Yes No
47. Are you bothered by poor quality sleep? ..... Yes No
48. Do you feel that you sleep too "lightly?" ..... Yes No
49. Do you feel that your sleep is not restful, no matter how much sleep you get? ..... Yes No

SNORING AND DIFFICULTY BREATHING DURING SLEEP

50. Do you snore? ..... Yes No
51. Have you been told that you snore loudly, or that your snoring disturbs others? ..... Yes No
52. Have you awakened yourself or someone else with your snoring sounds? ..... Yes No
53. Is snoring a source of distress in your marriage or other significant relationship? ..... Yes No
54. Has anyone ever told you that you seem to have difficulty breathing or that you stop breathing during sleep? ..... Yes No
55. Do you ever awaken with the sensation of shortness of breath? ..... Yes No
56. Do you ever awaken gasping, choking, or "gulping for air?" ..... Yes No
57. Do you often awaken with a dry mouth or sore throat? ..... Yes No
58. Do you ever awaken feeling disoriented or confused? ..... Yes No
59. Do you ever awaken with headaches? ..... Yes No
60. Do you use the restroom frequently at night? ..... Yes No
61. Do you experience "acid reflux," "acid indigestion," or dyspepsia? ..... Yes No
62. (Men) Do you have difficulty getting or keeping an erection? ..... Yes No
63. Have you had surgery for snoring or sleep apnea? ..... Yes No
64. Have you been treated for snoring or sleep apnea with a dental device? ..... Yes No
65. Have you been treated for snoring or sleep apnea with nasal CPAP, BiPAP, or Autopap? ..... Yes No

NARCOLEPSY

66. Have you ever experienced “sleep attacks” (sudden, irresistible urge to sleep)? ..... Yes No

67. Upon falling asleep or waking up have you ever had the experience of seeing things or hearing things that were not really there? ..... Yes No

68. Upon falling asleep or waking up have you ever had the experience of being unable to Move your arms or legs, even if you try? ..... Yes No

69. Have you ever done things during the day without having awareness of your actions? ..... Yes No

70. Have you ever had a seizure? ..... Yes No

71. Have you ever experienced sudden muscle weakness while awake (In mild conditions this could be experienced as a weak grip, or leg or arm weakness. In severe conditions, one’s legs might buckle and the person might fall to the floor) ? ..... Yes No

    If yes, was this brought on by an intense emotion? ..... Yes No

72. Do you start dreaming right after you fall asleep? ..... Yes No

SLEEP AND SLEEP-RELATED MOVEMENTS

73. Do you experience painful or unusual sensations of your legs while at rest, especially in the evening? ..... Yes No

74. Do painful or unusual sensations of your legs interfere with your ability to fall asleep? ..... Yes No

75. Do you experience painful or unusual sensation of your legs that awaken you, or that prevent you from returning to sleep if you wake up during your sleep period? ..... Yes No

76. If you answered yes to any of the above items, does walking or massage seem to relieve the discomfort in your legs? ..... Yes No

77. Do you ever experience “twitching” or “jerking” of your feet or legs while asleep? ..... Yes No

78. Do your leg movements disturb your bed partner? ..... Yes No

79. Do you notice that your hands and feet are cold prior to, during, or after sleep? ..... Yes No

SLEEP RHYTHMS

80. If employed, what are your usual work hours? ..... Start shift:_____ AM / PM End: _____ AM / PM

81. Are you a shift worker (evenings, nights, or rotating shifts)? ..... Yes No

82. Do you struggle to balance your shift work and family activities? ..... Yes No

83. Do you suffer from jet lag? ..... Yes No

84. Do you find that you typically fall asleep **earlier** than desired and awaken **earlier** than desired? ..... Yes No

85. Do you find that you typically fall asleep **later** than desired and awaken **later** than desired? ..... Yes No

PARASOMNIAS

86. Please indicate if you have experienced the following symptoms at any time. Please note the age that symptoms began and your age when they stopped. Place a checkmark in the column at the right to indicate an ongoing problem.

Problem Behavior	Check "yes" if past or current problem	Frequency/ week	Age when symptoms began	If stopped, age when last occurred	Ongoing problem?
Sleepwalking	Yes No				Yes No
Sleepwalking associated with "night eating"	Yes No				Yes No
Sleepwalking associated with injury to self/others	Yes No				Yes No
Nightmares	Yes No				Yes No
Night Terrors	Yes No				Yes No
Bed Wetting	Yes No				Yes No
Difficulty swallowing during sleep	Yes No				Yes No
Sudden unusual movements during sleep	Yes No				Yes No
Sleep talking	Yes No				Yes No
Other (describe):	Yes No				Yes No

MEDICAL STATUS AND HISTORY

87. Have you now, or have you ever in the past, received treatment for high blood pressure? ..... Yes No

88. Have you been told that you have an irregular heartbeat (cardiac arrhythmia)? ..... Yes No

89. Have you ever suffered a stroke? ..... Yes No

90. Have you ever sufferered a heart attack? ..... Yes No

91. Have you been told that you have GERD (gastroesophageal reflux disease), acid indigestion, or dyspepsia? ..... Yes No

If yes, why? _____

92. Have you ever been hospitalized for any reason? ..... Yes No

93. Have you ever had surgery? ..... Yes No

If yes, why? _____

94. Have you ever had a serious injury? ..... Yes No

If yes, why? _____

95. Please complete the following checklist by identifying medical conditions that you have now or have had in the past:

System	Type of problem	Date problem began	Ongoing or indicate date stopped
Head, eyes, ears			
Nose			
Sinuses			
Mouth and throat			
Lungs and chest (COPD)			
Heart (Heart attack, high blood pressure)			
Central nervous system (e.g., headaches, seizures)			
Digestive system (e.g., GERD)			
Musculoskeletal system			
Endocrine system (e.g., over-weight, diabetes, etc.)			
Skin			
Allergies (specify to what)			
Psychiatric			
Other			

MEDICATION USE

96. Please list all prescription and over-the-counter medications that you currently use.

Medication Name	Dose (if known)	Number Pills Taken per Day (if use is less than daily please indicate frequency of use)	Reason Used	Check Here if Medication is Used to Treat a Sleep Problem	Effectiveness	Prescribing Doctor

FOOD, BEVERAGES AND OTHER SUBSTANCES

97. For each beverage listed, indicate the average number of ounces you drink per day:

Regular coffee _____
Regular tea _____
Cola _____

98. Do you usually drink caffeinated beverages (coffee, tea, cola) within 6 hours before bedtime? ..... Yes No

99. Do you drink caffeinated beverages during the day to help you stay awake? ? Yes ? No

100. On average, do you consume more than 5 alcoholic drinks per day? ? Yes ? No

101. On average, do you consume more than 15 alcoholic drinks per week? ? Yes ? No

102. Do you drink alcohol (beer, wine, or hard liquor) shortly before bedtime? ? Yes ? No

103. Do you use alcohol to help you fall asleep? ? Yes ? No

104. Do you smoke cigarettes? ? Yes ? No

If yes, how many cigarettes do you smoke per day? _____

Do you smoke just before bed, or if you happen to awaken during your sleep period? _____

105. Do you smoke cigars or a pipe? ? Yes ? No

106. Do you use any illicit drugs (e.g., marijuana, cocaine, crack)? ? Yes ? No

107. Do you use any illicit drugs to help you fall asleep or stay asleep, or stay awake? ? Yes ? No

FAMILY AND SOCIAL HISTORY

108. Father's age: _____ If deceased, what was the year and cause of death?_____

109. Mother's age: _____ If deceased, what was the year and cause of death? _____

110. Number of siblings: _____ Ages of your children: _____

111. Does anyone in your family have any sleep problems? ? Yes ? No

If so, briefly describe and give their relationship to you: _____

112. Does anyone in your family have a history of serious medical or psychiatric problems? ? Yes ? No

If so, what is their problem and what is their relationship to you? _____

113. Is there any additional information regarding your sleep, medical, or family histories that you would like to add?

_____

_____

_____

Thank you for completing the Sleep Disorders Inventory". The information that you have provided will assist your doctor in evaluating and treating your sleep complaint. If you have completed this questionnaire in your primary care doctor's or specialist's office, you should review your answers with the doctor. You also may ask your doctor to submit your questionnaire to Sleep Disorders Institute for review. Please use the e-mail or the street address indicated below for all correspondence. If you have completed this questionnaire at the Sleep Disorders Institute, you may request a copy for your files or your doctor's medical record.

Your health is our first concern. For more information about sleep and sleep disorders, please visit www.getsleepfacts.com. For information about Sleep Disorder Institiute and its affiliates, you may visit our corporate Web site at www.sleepny.com. Please submit inquiries to info@sleepny.com.

Please return all completed questionnaires to:

Sleep Disorders Institute
330 W. 58th Street, Suite 509,
New York, New York 10019

Tel: 212-994-5100 • Fax: 212-994-5101
E-mail: info@sleepny.com
www.sleepny.com

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 range
10-12	Borderline
12-24	Abnormal