Sleep Disorders Centers
of the Mid-Atlantic

Dear Patient,
A sleep study has been scheduled for you at the SLEEP DISORDERS CENTER OF THE MID-ATLANTIC at this location:

☐ VIENNA	☐ FAIRFAX	☐ MANASSAS
2235 Cedar Lane, #202 Vienna, VA 22182	10875 Main Street, #212 Fairfax, VA 22030	7513 Presidential Lane Manassas, VA 20109

Your sleep study appointment is scheduled for

Upon arrival to the sleep center, you will be greeted by a technologist who will have you complete a bedtime questionnaire prior to attaching your sensors and monitors. You will typically be ready for bed by approximately 9:30-10:30pm and we ask that you try to go to sleep as early as possible so that we can maximize the time we have to collect the data. The study will be completed by approximately 5:00am – 6:00am. At this time you will be disconnected from your monitoring equipment and asked to complete a brief post study questionnaire. Although these bedtimes may not be typical for you, they are required for us to conduct the testing in the best manner possible. If you are unable to keep this appointment or should need to reschedule, please do so within at least 48 hours prior to your appointment, whenever possible.

ON THE DAY OF YOUR STUDY

- Bring comfortable, loose clothing or pajamas to sleep in.
- Bring any toiletries that you would need for an overnight stay (for ex. hotel stay).
- Any prescription medication that you need to take during your stay should be taken as you normally do, unless otherwise instructed by your physician.
- Completed paperwork/consent forms that were mailed to you with this letter.
- Insurance cards, and referrals if needed.
- Avoid alcohol and caffeine (coffee, tea, soda, and chocolate) after 12:00PM on the day of your study.
- Refrain from using hair gels, sprays, oils, make-up, and skin lotions as these can interfere with the sensors.
- Avoid taking a nap on the day of your study.
- We recommend that you eat prior to arriving to the sleep lab, since food will not be provided.

What is a Sleep Study?

A sleep study is a diagnostic procedure that records brain waves, heart activity, breathing patterns, muscle activity, eye movement, and oxygen saturation while you are sleeping. Several electrodes, sensors and monitoring equipment will be attached to your body with tape or paste prior to bedtime. These sensors transmit output data to a computerized recording that is continuously monitored by a qualified technologist. You will sleep in a comfortable Tempur-Pedic bed within a private room. The technologist will be monitoring and documenting throughout the night and will be available to assist you with anything you need, including assistance during trips to the restroom. You will also be video/audio monitored to document sleep position, snoring, and any other activity that occurs throughout the night.

If your physician has ordered a "split night study", the technologist will prepare you for the possibility of using CPAP (Continuous Positive Airway Pressure) therapy after approximately 2 hours of diagnostic monitoring. CPAP is a therapy used to treat obstructive sleep apnea. Positive air pressure is delivered through a nasal or nasal/oral mask and splints open the airway. This positive pressure will prevent obstruction or collapsing of the airway which causes apnea (pauses in breathing). During this portion of the testing, the technologist will adjust the levels of air pressure to determine which level best works for you. **We look forward to assisting you and your physician in improving your health and wellbeing. Feel free to contact us with any questions or concerns at 703-752-7881(Mon-Fri 9am to 5pm). If you have any problems or questions on the night of your test and are unable to reach the technologist at the *above phone number*, you may call the Chief Technologist on call at 703-504-8492.**

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DIRECTIONS TO THE SLEEP LABS:

VIENNA LOCATION:

2235 Cedar Lane, #202
Vienna, VA 22182

Press the button for Suite 202 and the Technologist will buzz you into the **building. Take the elevator/stairs to the second level, and then turn right.*

From Points North:
Take I- 495 South to Tysons Corner, Rt.7/Leesburg Pike (West). Take a left onto Gallows Rd. Turn right onto Cedar Lane (between the two Sunoco Gas stations). 2nd office building on the left (0.10 mile), just before the residential area.

From Points South:
Take I-495 North to Tysons Corner, Rt. 7/Leesburg Pike (West). Take a left onto Gallows Rd. Turn right onto Cedar Lane (between the two Sunoco Gas stations). 2nd office building on the left 0.10 mile, just before the residential area.

From Points West:
Take I-66 East to exit # 66 at Rt.7/Leesburg Pike. At the bottom of the ramp, turn left towards the Rt. 7/ Leesburg Pike WEST. Turn left onto Gallows Rd. and turn right onto Cedar lane - 2nd office building on the left.

From Points East:
Take I-66 West to exit # 66 at Rt.7/Leesburg Pike (west). Take a left onto Gallows Rd. Turn right onto Cedar Lane (between the two Sunoco gas stations) 2nd office building on the left.

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FAIRFAX LOCATION:

10875 Main Street, #212
Fairfax, VA 20109

Park in the garage, take the elevator/stairs to the 2nd floor, suite 212
Non-descriptive, 2-story Professional Building

From I-495 South (towards Richmond) to Rt. 236 (Little River Turnpike). Continue on Rt. 236 (Little River Turnpike) towards Fairfax. Little River Turnpike will become Main Street. Follow Main St. through Old Towne Fairfax. Approx. ¾ mile on the left (*just prior to US-50*). Turn left onto Hallman, then left into parking garage.

From I-66 - Take the Chain Bridge RD (VA-123) Exit. Continue southwest on Chain Bridge Rd(VA-123) toward Sager Rd. Turn Right onto West St. Turn Left onto Main St (Rt. 236). Turn left at Hallman St. and left into the parking garage.

From US-50 East. -Continue of US 50 E until you reach the intersection US-50/Rt. 236/I-29. Continue straight on to Rt. 236/ Main Street. Turn Right onto Hallman. Turn left into parking garage.

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MANASSAS LOCATION:

7513 Presidential Lane
Manassas, VA 20109

From I-66, take Exit 47A, stay in the Right lane. Continue through 3 traffic lights, at the third traffic light there will be a RACEWAY gas station. Immediately past the RACEWAY, there is an entrance into "Ambassador Square". Enter Ambassador Square and at the stop sign , make a right onto Presidential Lane. Follow the signs for Manassas Sleep Lab. If you have any problems or questions on the night of your test , you may call the Chief Technologist on call at 703-477-1191.

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CONSENT FOR RELEASE OF INFORMATION AND PHYSICIAN REIMBURSEMENT

I certify the accuracy of the patient and insurance information provided to the physician and authorize the release of any medical information necessary to process this claim. I authorize my insurance company to remit benefit payments directly to the physician.

X_____
Patient or Responsible Party Signature

FINANCIAL AGREEMENT

I understand that payment for any services not covered or denied by my insurance company (co-payment/insurance, deductible, pre-existing condition, failure to obtain a prior authorization/referral, etc.) will be my responsibility. I also understand that my insurance company may not cover certain preventative charges as spirometry, urinalysis, pulseO2, and stool hemocult testing and therefore authorize my physician to bill these charges to me instead of my insurance company. I understand that if my account is forwarded to a collection agency, I will be responsible for any and all reasonable collection fees and/or attorney fees.

Patients who have HMO Policies such as Optimum Choice, M.D.I.P.A., Aetna HMO, Cigna HMO, Trigon Healthkeepers, Medicaid Medallion, and Unicare are required to select a primary care provider before being treated. I understand that if I have an HMO Policy and have not selected the rendering physician as my primary care, I am waiving insurance benefits and will be responsible for payment.

X_____
Patient or Responsible Party Signature

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MEDICAL RECORDS RELEASE CONSENT

I, _____, hereby authorize Dr. James R. Perlstrom to release my

medical / psychological records to: _____.

Address: _____

Phone#: (_____)_____-_____Fax#: (_____)_____-_____

_____

Print name

X_____

Signature ***Date***

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VIDEO/AUDIO MONITORING CONSENT

As a part of our diagnostic sleep study, video surveillance may be required. All information and data will be kept strictly confidential.

_____I, hereby authorize the use of video surveillance for the purpose of medical diagnosis.

_____I do not consent to video surveillance during my testing.

_____

Print Name

X_____

Signature ***Date***

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Privacy Notice

The Department of Health and Human resources, Office of Civil rights, under the Public law104-191, (The Health Insurance Portability and Accountability Act of 1996)(HIPPA), mandates that we issue this newly revised Privacy Notice to our patients. This notice to our patients meets all current requirements as is relates to Standards of Privacy of Individually Identifiable Health Information IIHI); affecting our patients. You are urges to read this.

Our privacy notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: "any information, whether oral or recorded in any medium that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual".

Our office will use or disclose your PHI for purposes of treatment, payment, and other healthcare purposes as required to provide you the best quality healthcare services the we offer. It is our policy to control access to you PHI; and even in cases where access is permitted, we exercise a "minimum necessary information" restriction to that access.

You, as our patient, may revoke any Consent at any time and all use, disclosure, and administration of related healthcare services will be revised accordingly, with the exception of matters already in process. To revoke the Consent you will have to provide this office with a written request with you signature, date and specific instructions. Any revocation will not apply to information already used or disclosed.

You, the patient, have the access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes. If the physician agrees with the request, we are bound by law to abide to any changes.

Please sign and date below indicating that you have received the privacy notice. Thank you.

_X_____ _____

Signature of Patient or Patient Representative *Date*

Print Name

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Patient Information

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

Date of Birth: _____/_____/_____ Gender: Social Security#: _____-_____-_____

Address: _____
City State Zip Code

Home Phone #: (_____) _____-_____ Cell / Other: (_____) _____-_____

Occupation: _____ Marital Status:

Work Phone #: (_____) _____-_____ Employer:_____

Employer Address: _____
City State Zip Code

EMERGENCY CONTACT

Person to notify in case of emergency: _____ PH# (_____)_____-_____

Relationship to patient: _____

PRIMARY INSURANCE INFORMATION

Policy Holder's Name: _____ SSN#: _____-_____-_____

Relationship to patient: _____ Policy Holder's Date of Birth: _____/_____/_____

Name of Insurance Co.: _____ PH#: (_____) _____-_____

Policy/Member ID#: _____ Group#: _____

Claim Mailing Address: _____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: _____ SSN#: _____-_____-_____

Relationship to patient: _____ Policy Holder's Date of Birth: _____/_____/_____

Name of Insurance Co.: _____ PH#: (_____) _____-_____

Policy/Member ID#: _____ Group#: _____

Claim Mailing Address: _____

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SLEEP HISTORY QUESTIONNAIRE

Name:_____ Date of Birth: _____/_____/_____

Age: _____ Gender: _____ Height: _____ Weight: _____

Referring Doctor(s): _____ Self - Referred? _____

Please list any previously diagnosed sleep disorders: _____

Chief Complaint – **Patients**: Please briefly describe your main sleep problem and how long you have had this problem:

A. MEDICATION SURVEY

Please list all prescription and non-prescription medications you're currently taking.

Medication	Reason taken	Dose

Allergies?_____

B. PLEASE LIST ALL PAST OR PRESENT MEDICAL CONDITIONS OR SURGERIES

Please check if you have had any of the following:

( )Acid reflux
( )Allergies / Hay fever
( )Anemia
( )Anxiety
( )Asthma /Reactive Airway
( )Back Pain
( )Bipolar Disorder
( )Bleeding Disorder
( )Chronic Cough
( )Chest Pain
( )Dizziness
( )Emphysema
( )Enlarged tonsils/adenoids
( )Fibromyalgia
( )Headaches/Migraines
( )Heart failure / Heart attack
( )Head Injury or brain surgery
( )High Blood Pressure
( )Heart Murmur/Palpitations
( )Heartburn
( )Impotence
( )Muscle Aches/Cramps
( )Menopause
( )Parkinson's Disease
( )Prostate Disease
( )Seizures
( )Sinusitis
( )Stroke
( )Tuberculosis
( )Thyroid Condition
( )Weakness/Paralysis

Other:_____

C. SLEEP PATTERNS

1. ON WORKDAYS
   - What time do you go to bed? _____ : _____
   - What time do you get out of bed? _____ : _____
   - Usual amount of sleep you get: _____ hours
2. ON WEEKENDS/DAYS OFF/ HOLIDAYS
   - What time do you go to bed? _____ : _____
   - What time do you get out of bed? _____ : _____
   - Usual amount of sleep you get: _____ hours
3. How long does it take to fall asleep? _____
4. How many times do you awaken? _____
   a. How long do the awakenings last? _____
   b. List any symptoms or reasons for awakenings
   _____
5. Do you feel un-refreshed and still sleepy upon awakening? _____
6. How long does it take you to fully awaken in the morning? _____
7. How many hours of sleep does it take to make you feel rested? _____ hours
8. Do you wake up too early and are unable to go back to sleep? _____
9. Do you have a special routine when going to bed? _____
10. What is your usual sleeping position? _____
11. Do you take medication (prescription or over-the-counter) to help you fall asleep? _____
    If YES, what do you take? _____dosage_____
12. Do you have wandering thoughts or does your mind race while you are trying to fall asleep? _____
13. Do you sleep with a bed partner? _____
14. Does your sleep problem affect your bed partner? _____

D. DAYTIME SLEEPINESS

1. Are you sleepy during the day? _____
2. Has there been a recent change in your sleepiness? _____
3. Do you take naps? _____
   If yes, how often? _____times a week
   Do you dream during these naps? _____
   Are these naps refreshing? _____
4. Have you ever experienced weakness or paralysis while laughing or angry? _____
5. Have you ever had hallucinations or dreamlike images while not actually asleep? _____
6. Do you have trouble concentrating or have difficulty remembering things? _____

Grade your tendency to *FALL ASLEEP* during the following situations:

(scale: 0=would never sleep, 1=slight chance of sleeping, 2=moderate chance of sleeping, 3=high chance of sleeping)

	0	**1**	**2**	**3**
a. Sitting and reading				
b. Watching TV				
c. Sitting active in a public place(e.g. theatre or meeting)				
d. As a passenger in a car for an hour without a break				
e. Lying down to rest in the afternoon				
f. Sitting and talking to someone				
g. Sitting quietly after lunch without alcohol				
h. In a car, while stopped for a few minutes				

_____ Epworth Score

E. SLEEP AND BREATHING

( ) Do you snore?
( ) Do you snore every night?
( ) Does your snoring disturb others?
( ) Does your sleep position affect your snoring?
( ) Have you or anyone else noticed pauses in your breathing during sleep?
( ) Have you ever awakened gasping, or short of breath?
( ) Do you awaken with a dry mouth or throat?
( ) Do you have morning headaches?
( ) Do you breathe through your mouth while you are asleep?
( ) Do you have difficulty breathing through your nose?

F. SLEEP DISTURBANCES

( ) Do you experience unpleasant leg or arm sensations at bedtime?
( ) Do you kick or jerk your legs during sleep?
( ) Do you have pain that delays or prevents you from falling asleep?
( ) Do you have pain that awakens you from sleep?
( ) Do you have frequent nightmares or vivid dreams?
( ) Do you grind your teeth or have bitten your cheek during sleep?
( ) Have you ever walked or talked in your sleep?
( ) Have you ever been unable to move for a few moments as you are awakening from sleep?
( ) Have you ever had unusual movements or behaviors during sleep?
( ) Have you ever wet the bed (as an adult)?
( ) Have your ever fallen out of bed (as an adult)?
( ) Do you get out of bed frequently to urinate?

G. SOCIAL HISTORY

( ) Do you currently smoke? If YES, how much per day?_____
( ) Have you ever smoked? If YES, how many years?_____ how much_____
( ) Do you drink alcohol?
( ) Do you consume caffeine (soda, coffee, tea, chocolate, etc)?
If YES, how much daily?_____

H. FAMILY HISTORY

Is there a family history of…..?	SLEEP APNEA	HEAVY SNORING	NARCOLEPSY	INSOMNIA	RESTLESS LEG SYNDROME	OTHER SLEEP DISTURBANCES
Mother						
Father						
Sister						
Brother						
Grandparents						

Have you ever had a sleep study or undergone sleep testing? If so, when? _____
where? _____