Tucson Pulmonology, PC

Next Scheduled Appt:_____

Patient name: _____

Patient DOB: _____

Durable Medical Equipment Company:

Does patient have a DME company? Y N

If so, who? _____

If no, OK to send any orders to the preferred one for patient's insurance? Y N

If no, who would patient like order sent to: _____

Messages:

OK to leave voicemail with results? Y N

If yes, preferred number: _____

If no, preferred method to receive results: _____

If Equipment is recommended:

OK to send order after informing patient? Y N

If no, what steps would patient like staff to take: _____

Additional testing:

OK to order any additional testing if recommended? Y N

If no, what steps would patient like staff to take: _____

All information has been confirmed:

Staff Initials: _____ Date: _____

Tucson Pulmonology, PC

Patient Name_____

Date ordered_____

Date of Home Sleep Study Setup_____/Date of Return_____

It is my privilege to provide you with the best healthcare to prevent and lessen the effects of disease and I remain committed to your comfort, convenience, and satisfaction. I am also committed to offering you the best healthcare at the lowest cost. As such, I would like to share some very important information about Obstructive Sleep Apnea (OSA).

More than 18 million Americans are thought to have OSA. It is a physical condition in which breathing repeatedly stops and starts during the sleep cycle. The result is an interruption in breathing that lasts for at least 10 seconds. It is considered severe when it occurs every two to three minutes.

This letter is intended to make you aware of a very important study about OSA that demonstrated that 46 percent of people who are undiagnosed with sleep apnea are at risk for a number of life-threatening health problems, such as heart attack, high blood pressure, & diabetes. Yet, four in five people are unaware they have the condition, and are not getting treatment!

Symptoms include:

Loud snoring	Always tired, trouble concentrating and staying awake	Waking with headaches
Waking with a choking sensation	Excessive sweating at night	Waking with dry mouth
Depression	Heartburn	Increased sexual dysfunction
Frequent trips to the bathroom at night	Restless sleep, tossing and turning	Rapid weight gain

Diagnosing OSA used to require an overnight stay in a sleep lab or hospital, attached to wires, in an unfamiliar bed and is rejected by many patients.

Now there is a new FDA approved wireless device that can be worn while you sleep in your own bed, in the comfort of your own home. The sleep study data that is gathered during your sleep is interpreted and I can recommend the best therapy.

For your convenience I am enclosing a brief self-administered survey about Sleep Apnea risk factors. Please take a moment to complete the survey and return it to my office so that I may determine if an appropriate course of action is warranted.

Thank you for allowing me to be part of your healthcare team.

Sincerely,

Your Tucson Pulmonology Team

Ubair Ahmed, MD, FCCP, FACP
Khaled Hadeli, MD, FCCP
Antara Mallampalli, MD, FCCP
Christopher Neal, FNP

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Neil Clements Jr., MD, FCCP
YuYa Huang, MD, FCCP
Sunil Natrajan, MD, FCCP
Sarah Meier, FNP

Tucson Pulmonology, PC

Date: _____

Dear Patient:

At Tucson Pulmonology, PC, we are always striving to improve our patient's health by staying current in both our techniques and diagnostic equipment. Recently we purchased a new technology that will allow you, the patient, to have your sleep studied in the comfort of your own home. Many of our patients were uncomfortable with the cost and process of outpatient sleep laboratories and we are excited to bring this new, easy to use and economical solution to our patients.

Unfortunately, not all insurance carriers have updated their policy to include coverage of this new testing solution. It may still be more economical as a non-covered service than being tested in the sleep clinic. Tucson Pulmonology, PC, encourages you to explore all options available to you and make the most educated decision that is best for you. If you do choose to move forward with our Home Sleep Test, please read the financial responsibility section below.

FINANCIAL RESPONSIBILTY

I understand that my insurance company is being billed as a courtesy and I agree that I am financially responsible to pay for any charges not covered by my insurance company. I also understand if I willfully damage the machine that I may be responsible for any costs that TPPC accrues.

Patient Name _____

Patient Signature _____

Date _____

Staff Member Signature _____ Date _____

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Confidential Document
To Remain Secured

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While the monitoring device is in my possession, I agree to exercise care in its use and handling, and return it within the promised time frame in working condition. I understand that delays in its return causes problems for other patients who need this service.

FINANCIAL RESPONSIBILTY

I understand that if the device is lost, stolen or damaged while in my possession, I am responsible to pay Tucson Pulmonology, PC, for the replacement of this device.

I am checking this device out on _____(date) and I agree to return it on _____(date) **(before 9 am**) at the conclusion of my sleep test so that other patients may have the same opportunity to be tested as I did. If I do not return it by the date above I agree to pay a $ 50.00 per day late fee until the equipment is returned.

I understand that I am responsible for the equipment and that it needs to be returned in good working order and intact. An inspection will be required upon its return to the practice with a staff member confirming the equipment is in satisfactory condition.

Patient Name _____

Patient Signature _____

Date _____

Date Returned:_____

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First Name	Middle Initial	Last Name	Tally ARES Risk Points

Weight	Pounds	**Age**	Years	Gender	Male ◯ Female ◯
Height	Feet / Inches	**Neck Size**	Inches		Neck Size +2 Male ≥16.5 +2 Female≥15.0
Date of Birth	Month / Day / Year	**ID Number**	Optional		Score

COMPLETELY FILL IN ONE CIRCLE 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 leg syndrome	Yes ◯	No ◯
Narcolepsy	Yes ◯	No ◯	Morning Headaches	Yes ◯	No ◯
Sleeping 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 to mark 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	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

Assign points for each of the first three responses

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

Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you wake up choking or gasping?

Never ◯ 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 ◯ 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 ◯

Signature	Area Code	Phone Number	**Total all 6 boxes from above**	**Point Total**
			If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	

Tucson Pulmonology, PC

Acknowledgement of Home Sleep Testing Instruction

- I understand that with any equipment used by multiple people that there is always a chance for the spread of communicable diseases, however, Tucson Pulmonology has taken appropriate steps to reduce this chance significantly. I also understand the Tucson Pulmonology, PC is not responsible for spread of any communicable disease, that I am using this equipment for diagnostic purposes at my own free will.

- I acknowledge the machine was cleaned in my presence.

- This is to acknowledge that you understand the instructions given to you by the Medical Assistant on how to use the home sleep testing device.

- My physician has explained the sleep study to me as well as the benefits and risks of having the test performed. I have had the opportunity to ask my physician and the Medical assistant questions, and I consent to the sleep study.

- I was shown in detail and in-person how to apply the Home Sleep Testing equipment by a Medical Assistant as well as given reference materials to take home with me. I understand that I am to sleep in my normal sleeping position and keep everything as I usually do when I sleep.

- I will bring back the Home Sleep Testing Equipment the next business day by 9 am (unless special arrangements have been made with the TPPC staff) or I will be charged for the equipment which could be up to $2000.00

_____ _____

Printed name of person providing instruction Signature of person providing instruction

_____

Patient Name

_____ _____

Patient Signature Date