Appointment Date
_____/_____/_____

Sleep Study Consent

PSG, CPAP, BiPAP, MSL T and/or MWT

I have either self-referred or have been referred by my physician to AMDx, Ltd. (dba, NeuroDiagnostic Laboratories) for sleep therapy to further understand my medical condition.

Diagnostic sleep studies involve the placement of electrodes on the scalp, face, neck, chest, hand(s), and leg(s) to measure and record brain activity, heart activity, respiration, body movement, blood oxygen content, and rapid eye movement (REM) to determine levels of sleep. Patients will be monitored via audio and video using an infrared video camera and an intercom system.

The sleep technologist will not be able to share any information about the study with patients until the physician has reviewed all of the data collected. The sleep study results are typically available within one (1) week of the date of the study. Please keep in mind, every patient and their condition(s) are unique therefore not every sleep study will result in a confirmed diagnosis. There are no known side effects of this type of testing. The alternative to this type of testing is to not have it performed, where the information regarding a potential sleep disorder will not be obtained.

I HAVE BEEN ADVISED OF AND UNDERSTAND THE DEFINITIONS AND PROCEDURES DESCRIBED WITHIN THIS DOCUMENT AND AGREE TO PROCEED WITH THE SLEEP STUDY

Patient Name (printed):_____**Patient Signature**: _____

If applicable, please print the name of the patient's representative:

_____ Relationship to the patient _____

Representative Signature: _____

Appointment Date
_____/_____/_____

Acknowledgement of Shared Patient Information and Treatment Plan

If you are diagnosed with sleep apnea, your results and a signed prescription for either a continuous positive airway pressure (CPAP) machine or a bilevel positive airway pressure (BiPAP) machine will be faxed to the durable medical equipment (DME) company listed below. The DME Company will contact you to set up an appointment at which time you will receive your new PAP machine and all supplies. At this time, a representative at the DME Company will also review your insurance benefit information.

IMPORTANT: If you have not been contacted by the DME Company noted below within the next 3-4 business days please contact them at the provided number.

Within 30-60 days of receiving your new PAP machine, a team member from NeuroDiagnostic Sleep Centers will contact you to schedule a follow up appointment at our office. At this time our provider will access your PAP data and review a performance report with you. If needed, corrective action or recommendations for improved performance will also be discussed.

DME Company: _____

Phone Number: _____

I HAVE BEEN ADVISED AND ACKNOWLEDGE THAT AMDX, LTD (DBA, NEURODIAGNOSTIC LABORATORIES) WILL SHARE MY STUDY RESULTS AND PRESCRIPTION WITH THE DME COMPANY SUPPLYING MY SLEEP THERAPY EQUIPMENT.

Patient Name (printed): _____

Patient Signature:_____ Date: ____/____/____

If applicable, print the name of the patient's representative: _____

Relationship to Patient: _____

Representative Signature: _____

Neuro Diagnostic Sleep Centers

Appointment Date
_____/_____/_____

Bedtime Questionnaire

Patient name: _____ DOB: _____/_____/_____

Please Complete All Sections and Print Clearly

Did you take any naps today? ☐ NO ☐ YES

Did you have any caffeinated beverages today? ☐ NO ☐ YES

If yes, at what time and how many?_____

Did you have any alcoholic beverages today? ☐ NO ☐ YES

If yes, at what time and how many?_____

Did you take any medications to help you stay awake? ☐ NO ☐ YES

If yes, what medication(s)?_____ At what time? _____

Did you take any sleep aids today? ☐ NO ☐ YES

If yes, what sleep aids?_____ At what time? _____

Patient Name (printed): _____

Patient Signature: _____ Date: _____/_____/_____

If applicable, please print the name of the patient's representative: _____

Relationship to the patient: _____

Representative Signature: _____

Neuro Diagnostic Sleep Centers

Appointment Date
_____/_____/_____

Morning Questionnaire

Patient Name:_____ DOB:_____/_____/ _____

Please Complete All Sections and Print Clearly

How long do you think it took for you to fall asleep last night? ☐ 0-30 Minutes ☐ 30-60 Minutes ☐ Longer

Compared to your normal sleep, how did you sleep last night? ☐ Better ☐ Same ☐ Worse

Compared to your normal sleep, how much sleep did you get last night? ☐ More ☐Same ☐ Less

Do you feel last night's sleep was adequate? ☐ NO ☐ YES

How many times do you think you woke up last night? ☐ Unsure ☐ Not at all ☐_____times

Please make **ONE** selection that best describes how you felt when you woke up this morning:

☐ Active, vital, alert, and awake

☐ Foggy, not able to concentrate

☐ Relaxed, awake, but not at full alertness

☐ Sleepy, fighting to stay awake

Did anything bother you during the night? ☐ No ☐ Yes

Explain:_____

Patient Name (printed):_____

Patient Signature: _____ Date:_____/_____/_____

If applicable, please print the name of the patient's representative:

_____, Relationship to the patient _____

Representative Signature: _____

Appointment Date
_____/_____/_____

Driving Recommendation and Acknowledgement

Driving while groggy, sleepy, and/or under the influence of any medication that may cause drowsiness can be dangerous, potentially leading to serious injuries or even death. It is the opinion and strong recommendation of the management, staff and/or other affiliates of AMDx, Ltd. (dba, NeuroDiagnostic Laboratories) that if you feel groggy or tired the morning following your sleep study that you arrange for alternative transportation home from the sleep facility. We are not responsible for any adverse actions or events that may occur should you choose to decline alternate transportation options.

As a courtesy to our patients, we provide a small selection of coffee at each sleep center. However, we do not offer breakfast items or food of any kind. If you require a meal or snack in the morning, please bring food with you.

I HAVE BEEN ADVISED OF AND FULLY UNDERSTAND THE DRIVING RECOMMENDATIONS MADE BY THE MANAGEMENT, STAFF AND/OR OTHER AFFILIATES OF AMDx, Ltd. (dba, NEURODIAGNOSTIC LABORATORIES) AND HAVE MADE THE FOLLOWING DECISION REGARDING MY TRANSPORTATION:

☐ I have arranged for alternative transportation (friend/family member, taxi, ride share, public transportation).

☐ I have DECLINED to arrange alternative transportation*

By DECLINING to arrange alternative transportation, I accept full responsibility for any adverse actions and/or events that may result from my decision.*

Patient Name (printed): _____

Patient Signature: _____ Date: _____/_____/_____