St. Charles
SLEEP CENTER
Bend · Redmond

PATIENT INFORMATION

Dear Patient:

Sleep problems are extremely common. Public health and safety are threatened by the increasing prevalence of obstructive sleep apnea, which now afflicts at least 25 million adults in the U.S., according to the National Healthy Sleep Awareness . Insomnia may be present in 15% to 20% of the population on a chronic basis. All of these disorders affect daytime wakefulness to a different degree in each person. For instance, some people with moderately severe sleep apnea claim to have little or no symptoms of daytime sleepiness, while individuals who only manifest snoring during sleep may feel terribly sleepy during the day.

You should be aware that any nighttime sleep disturbance may cause daytime drowsiness and therefore could impair your ability to operate heavy machinery (especially a motor vehicle). You should not expose yourself or others to harm because of your potential drowsiness.

Obviously, each person must use his/her **best judgement** to determine if placing himself/herself in a particular setting (e.g. driving a car, or working at heights) might lead to harm to himself/herself or to others.

For our protection, we require verification that you have received this notice. Therefore, please sign below.

Thank you,
St. Charles Sleep Center

I hereby acknowledge the foregoing risks and with full knowledge do consent to voluntary participation in the sleep lab program.

Patient Signature:_____ Date:_____

Patient Care Team

Who is involved in your care?

This form has been created to help all providers involved in your care know what additional support systems you have currently.

Name: ____ City/State: ____________________________ Phone: ________________

Title:

- Primary Care Physician (PCP)
- Specialist___________________ (heart, lung, etc)
- Community Health Worker (CHW)
- Home Health Care Specialist
- Nurse Care Coordinator (RNCC)
- Behavioral Health Consultant
- Personal Caregiver (friend, family, etc)

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PRE-EPWORTH SCALE

Name_____Date_____

Your Age _____ Your Sex: ☐Male ☐Female

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just 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 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:

1. Sitting and reading ..... _____
2. Watching TV..... _____
3. Sitting, inactive in a public place (e.g. a theater or a meeting)..... _____
4. As a passenger in a car for an hour without a break..... _____
5. Lying down to rest in the afternoon when circumstances permit ..... _____
6. Sitting and talking with someone ..... _____
7. Sitting quietly after lunch without alcohol ..... _____
8. In a car, while stopped for a few minutes in traffic ..... _____

Score _____

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The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half The Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals: _____ + _____ +_____ +_____

Add Totals Together: _____

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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SPOUSE/ROOMMATE QUESTIONNAIRE

Patient Name_____Date_____

PLEASE HAVE SPOUSE/ROOMMATE COMPLETE.

Check any of the following behaviors you have observed the patient doing.			
WHILE ASLEEP		**WHILE AWAKE**	
	Loud snoring		Depression
	Light snoring		Change in personality
	Twitching of legs or feet		Loss of intellectual function
	Pauses in breathing		Excessive daytime sleepiness
	Grinding teeth		Weight gain
	Sleep walking		Fatigue
	Bed wetting		Morning headache
	Sitting up in bed not awake		Irritability
	Kicking of the legs		
	Getting out of bed not awake		
	Sleep talking		

How long have you been aware of the sleep behavior that you checked above?

_____

_____

Describe the sleep behavior described above in more detail. Include the type of activity, the time of night in which it occurs, frequency during the night and whether it occurs every night.

_____

_____

_____

If you have described loud snoring, do you remember hearing short pauses in the snoring or occasional loud snorts?

_____

About Your Billing Statements

Why am I receiving two separate billing statements?

- St. Charles Health System is an integrated healthcare delivery system that includes hospitals, outpatient services, and numerous clinic locations throughout central Oregon.
- The St. Charles Sleep Center provides physician services and outpatient testing facilities.
- The care you receive at the Sleep Center will be billed on two statements.
- St. Charles Medical Center will bill technical charges for diagnostic testing. Statements from St. Charles Medical Group will include physician professional charges and the facility charges for clinic visits performed at one of our outpatient clinics**.**

What is a Facility Charge?

Our physicians practice at a hospital outpatient facility to provide the highest standard of care and quality to you. If you receive care at one of our locations, certain outpatient services and procedures may result in a hospital facility charge as well as a professional or physician charge. Depending on insurance coverage your plan may apply different benefits to outpatient facility services, resulting in additional deductible or co-payment amounts being due. We recommend that you review your insurance benefits or contact your insurance provider to determine what will be paid, and what, if any, out-of-pocket expenses will be incurred.

Patients with questions or concerns regarding billing statements should call:

St. Charles Medical Group, Centralized Billing Office: (541) 516-3866

St. Charles Health System (St. Charles Medical Center), Patient Financial Services: (541) 706-7750