HEALTH SYSTEM

Huntsville Sleep Center
245 Governor's Drive SE
Huntsville, AL 35801
Phone 256-265-8553 Fax 256-265-7082

Madison Sleep Center
8020 Highway 72 W, Suite D
Madison, AL 35758
Phone 256-265-5977 Fax 256-722-3011

Dear _____,

Your initial evaluation has been scheduled with _____ on _____.

Please arrive at _____ AM/PM for your appointment at _____AM/PM.

The Huntsville Sleep Center is located inside the **WOMEN & CHILDREN'S HOSPITAL** (formerly Huntsville Hospital East) on the ground floor. You may park in any patient parking area around the Women & Children's Hospital. There is limited free parking in the front of the hospital. There is additional parking available in the lot beside the hospital for a $2.00 fee. Valet parking is also available for a $5.00 fee. The Sleep Center is able to validate under special circumstances ONLY. Please speak with the office staff when you arrive or call prior to your appointment for more information.

The Madison Sleep Center is located on the corner of Highway 72 West and Wall Triana Hwy, in the old Southern Family Market complex. We are beside Madison Hospital, Physical Therapy.

Please complete the enclosed paperwork and bring it with you to your appointment. You will also need to bring your insurance card(s) and a photo ID. We ask that you arrive 30 minutes early in order to process this paperwork into your medical records. If you are late by 10 minutes or more, your appointment may have to be rescheduled. **If you are scheduled for a 1:00 p.m. appointment, please do not arrive early as our office is closed for lunch from 12:00 – 1:00 p.m.**

Our office staff will contact you to confirm your appointment. **Please call us at least 24 hours in advance if you need to cancel or reschedule your appointment.** Excessive cancellations or no shows may only be rescheduled with the Sleep Center's physician's approval or a new referral.

Your initial evaluation allows you to speak with the doctor, one on one, regarding any symptoms and/or concerns you may have with your sleep. Plan to be here approximately an hour. If it is deemed necessary by the physician that you undergo sleep testing, an appointment will be scheduled before you leave the Sleep Center.

In consideration of those with breathing disorders and other sensitivities, we are a fragrance free facility. Please refrain from wearing perfume, scented lotions or cologne to any appointments or sleep testing.

Please contact us if we can be of further assistance. Our business hours are 8:00 a.m. - 4:30 p.m. Monday through Thursday, closed for lunch 12:00 - 1:00 p.m., and 8:00 a.m. - 12:00 noon Friday.

Sleep Center Registration

Patient Name_____ DOB_____
SS#_____ Marital Status (circle one) S M D W Sex M / F

Primary Care Physician _____

Race (circle one) Asian Black/African American White/Caucasian American Indian or Alaska Native
Hispanic/Latino Other Pacific Islander More than 1 race Do not wish to report

Preferred Language ___English ___Spanish ___French ___Creole ___Other _____

Address_____
City_____ State_____ Zip_____
County_____ Home Phone_____ Cell_____
Email Address_____

Employment Status (circle one) Full Part Self Retired Unemployed Active Duty Military
Employer_____
Address_____
City_____ State_____ Zip_____
Phone_____

Spouse Name _____ DOB _____
Address_____
City_____ State_____ Zip_____
Cell Phone_____ Work _____
Spouse Employer_____
Address_____
City _____ State_____ Zip_____

Emergency Contact _____Relationship to Patient_____
Address_____ _____
City_____ State_____ Zip_____
Phone_____ Work _____

Guarantor if other than Patient _____
Relationship_____ DOB_____ SS#_____
Address_____
City_____State_____ Zip_____
Home Phone_____ Cell _____Work_____

Primary Insurance
Subscriber Name _____Relationship to Patient_____
Insured SS#_____ DOB_____
Insured Employer _____
Address _____
City_____ State_____ Zip_____

Secondary Insurance
Subscriber Name _____Relationship to Patient_____
Insured SS#_____ DOB_____
Insured Employer_____
Address_____
City_____ State_____ Zip_____

HEALTH SYSTEM

HUNTSVILLE HOSPITAL & MADISON HOSPITAL SLEEP CENTERS

BILLING AND INSURANCE INFORMATION

Sleep disorders are recognized as medical problems. However, individual insurance carriers vary in their claim submission requirements and reimbursement policies. For this reason, the Sleep Center handles billing in the following manner:

OFFICE VISITS

The Sleep Center collects co-payments at the time of service. The amount of your copay is determined by your insurance company. Any questions regarding insurance coverage or status of your bill should be directed to your physician's private office.

***Dr. Robert Serio or Reiga Luedemann, MSM, PA-C:** Huntsville Lung Associates can be reached at 256-533-6003. Forms of payment accepted are cash, check, Visa, Master Card, Discover Card, and American Express.

***Dr. Darren Gannuch:** Alabama Sleep Disorder Center can be reached at 256-882-2003. Forms of payment accepted are cash or check only.

***Dr. Bahador Tafazoli**: Cullman Primary Care, Family/Sleep Medicine can be reached at 256-775-1090. Forms of payment accepted are cash and check only.

***In addition, Huntsville Hospital's business office will file a claim with your insurance for the services rendered by the hospital. For billing inquiries please call 256-265-9569.**

SLEEP CENTER TESTING

If testing is scheduled for you, we recommend that you contact your insurance carrier to verify coverage. **The Sleep Center does not verify coverage.** Some carriers may require prior authorization or precertification for your testing. **It is your responsibility to notify your physician and the Sleep Center if prior authorization or precertification is required for your services to be covered.**

If you find that your insurance carrier does not cover sleep testing, please contact us.

Diagnostic testing includes any procedure performed overnight or the next day. Any diagnostic procedure your physician orders will be explained prior to scheduling.

For insurance purposes the following codes are provided:

Procedure	Procedure Code	Procedure	Procedure Code
Adult Polysomnography (NPSG)	95810	Child Polysomnography (NPSG)	95782
Adult Polysomnography with CPAP/BIPAP	95811	Child Polysomnography with CPAP/BIPAP	95783
Multiple Sleep Latency Test (MSLT)	95805		
Maintenance Wakefulness Test (MWT)	95805		
ARES (Home testing device)	95800		
Overnight Pulse Oximeter (Home testing)	94762		

After your overnight sleep study you will receive two billing statements. One statement will be from the hospital for the diagnostic testing. The second will be for the interpretation fee from your physician. Please know that you may be scheduled for multiple procedures depending on your clinical condition. Any questions regarding the status of the bill should be directed to the phone number on your statement. Any questions regarding insurance coverage should be directed to your physician's private office.

***Huntsville Lung Associates:** 256-533-6003 for Dr. Serio

***Pulmonary and Sleep Assoc. of Huntsville, PC:** 256-883-2112 for Dr. Sneeringer or Dr. Vuppala

***Roy Sleep Medicine:** 256-213-1800 for Dr. Roy

***Alabama Sleep Clinic:** 256-539-2531 for Dr. Hearn

***Alabama Sleep Disorder Center:** 256-882-2003 for Dr. Gannuch

***Cullman Primary Care, Family/Sleep Medicine**: 256-775-1090 for Dr. Tafazoli

Revised: 1/20/15 DA

Pediatric Sleep History and Symptom Form

Mark Tafazoli M.D., DABFP, CAQSM
Huntsville Sleep Center – 245 Governors Drive, SE Huntsville, AL 35801 Phone: (256) 265-8553 Fax: (256) 265 -7082

Name_____ Age____ ❑Female ❑Male DOB_____/_____/_____Today's Date _____/_____/_____

What brings your child to our office today?

_____
_____
_____

Child's Main Complaints:	**Parent's main complaint (about child's sleep)**
❑Daytime sleepiness	❑Daytime sleepiness
❑Insomnia	❑Insomnia
❑Snoring	❑Snoring
❑Interruptions in breathing	❑Interruptions in breathing
❑Leg jerks	❑Leg jerks
❑Other_____	❑Other_____

Sleep history:
How long has your child's complaints bothered him/her?
❑Last 3 months ❑6-12 months ❑1-2 years ❑>2 years

How would you rate the severity of your child's complaints:
❑Mild ❑Moderate ❑Severe

Has the child had a previous sleep study? ❑Yes…..❑ No….When_____ Where_____ Physician_____
What was recommended?_____

Sleep Schedule
(1) During the week …..What time does your child normally go to bed _____ a.m. / p.m. Total sleep time in 24hrs_____
What time does your child normally awaken _____a.m. / p.m.
(2) During the weekend..What time does your child normally go to bed _____ a.m. / p.m.
What time does your child normally awaken _____ a.m. / p.m.
(3) How long does it take your child to get to sleep? _____ min / hours
(4) Approximately how many times does the child awaken during their sleep cycle? _____ How long to get back to sleep? _____
(5) What are the usual reasons that awaken the child?

❑Urination	❑Heat
❑Shortness of breath	❑Cold
❑Heartburn	❑light
❑Body Jerks	❑Pain
❑noise	❑Sibling
❑other_____	

	Check if applicable	
(6) Does your child sleep through the night?	❑yes	❑ no
(7) Does your child sleep with parents bed/bedroom?	❑yes	❑ no
(8) Does anyone leave the bedroom b/c of your child's sleep problem?	❑yes	❑ no
(9) Does the child awaken feeling tired and not refreshed?	❑yes	❑ no
(10) Take naps on arrival home from work/school?	❑yes	❑ no
(11) Are short naps refreshing?	❑yes	❑ no
(12) Does your child fall asleep while driving or riding in a car?	❑yes	❑ no
(13) Have trouble at work or school b/c of sleepiness?	❑yes	❑ no
(14) Snore loud enough for others to complain?	❑yes	❑ no
(15) Stop breathing?	❑yes	❑ no
(16) Awakened short of breath or choking?	❑yes	❑ no
(17) Awakened with heart burn belching or coughing?	❑yes	❑ no
(18) Awakened with chest pain or chest heaviness?	❑yes	❑ no
(19) Awakened with heart racing or pounding?	❑yes	❑ no
(20) Wake up with morning headache?	❑yes	❑ no
(21) Have poor memory?	❑yes	❑ no
(22) Trouble concentrating?	❑yes	❑ no

(23) Has your child's family relationship been affected b/c of they are tired or sleepy?.....	❑yes	❑ no	
(24) Does your child feel the uncontrollable urge to sleep while sad, happy or mad?	❑yes	❑ no	Narcolepsy screening
(25) Feel their knees buckle arms weak, or jaw drop when mad happy or sad?.....	❑yes	❑ no	
(26) Experience vivid dream-like scenes upon awakening or falling sleep? ……	❑yes	❑ no	
(27) Feel unable to move (paralyzed) when waking from or falling asleep?.....	❑yes	❑ no	
(28) Have leg cramps at bedtime? …….…….……	❑yes	❑ no	PLM screening
(29) Experience crawling and aching feeling in arms or legs which makes him/her want to move them?.....	❑yes	❑ no	
(30) Leg move throughout the night? …….……	❑yes	❑ no	
(31) Awaken suddenly with a jerk soon after falling asleep?.....	❑yes	❑ no	
(32) Remember his/her dreams? ……..	❑yes	❑ no	Parasomnia Screening
(33) Have nightmares?.....	❑yes	❑ no	
(34) Act out his/her dreams (talk or move)? ……..……..	❑yes	❑ no	
(35) Sleepwalk?.....	❑yes	❑ no	
(36) Awaken from sleep confused / inconsolable? ……..	❑yes	❑ no	
(37) Awakened panicked or anxious?.....	❑yes	❑ no	
(38) Unable to fall asleep in 15 minutes or less? ……..……	❑yes	❑ no	Insomnia screening
(39) Wake up several times during the night and cannot get back to sleep?.....	❑yes	❑ no	
(40) Wake up 1 or 2 hours early in the morning? ……	❑yes	❑ no	
(41) Have thoughts racing through his/her mind while trying to sleep?.....	❑yes	❑ no	
(42) Watch the clock while trying to fall asleep? …….……	❑yes	❑ no	
(43) Wake up stiff in the morning?.....	❑yes	❑ no	Depression/fibromyalgia
(44) Wake up with sore achy muscles?	❑yes	❑ no	screening
(45) Feel depressed or sad?.....	❑yes	❑ no	
(46) Clench their teeth? ……..	❑yes	❑ no	Bruxism screening
(47) Grind teeth during sleep?.....	❑yes	❑ no	
(48) Have morning jaw pain? ……	❑yes	❑ no	

Epworth Sleepiness Scale Please check all that applies to your child.
How likely is your child to doze off to sleep in the following situations?

Situation	(0) would never doze	(1) Slight chance of dozing	(2) Moderate chance of dozing	(3) high chance of dozing
1- Sitting Reading_____	❑	❑	❑	❑
2- Watching TV_____	❑	❑	❑	❑
3- Sitting, inactive in a public place (i.e. theater or meeting)_____	❑	❑	❑	❑
4- As a passenger in a car for an hour without break_____	❑	❑	❑	❑
5- Lying down to rest in the afternoon when circumstances permit_____	❑	❑	❑	❑
6- Sitting down talking with someone_____	❑	❑	❑	❑
7- Sitting quietly after lunch without alcohol_____	❑	❑	❑	❑
8- In a car, while stopped for a few minutes in traffic_____	❑	❑	❑	❑

Epworth Total____/ 24

<u>Birth history:</u> Please answer to the best of your recollection regarding child:

Did the child's mother receive regular prenatal care while pregnant? □ Yes…□ No…
Were there any complications during pregnancy with this child? □ Yes…□ No… If yes, explain _____
Were there any complications post delivery with this child? □ Yes…□ No… If yes, explain _____
Birth Weight _____ #wks of gestation _____ Length of labor _____ APGAR score _____@ 5 mins
Type of delivery? □SVD (vaginal)….. □C-section Any birth defects / trauma ….□Yes…□No… If yes, explain _____
Jaundice…□Yes…□No Prolonged neonatal stay? ….□Yes….□No… If yes, explain _____
Other_____

Social History: Please check all that applies to your child:

Number of siblings _____ Does child have own room? □ Yes…□No Does the child sleep in their own bed? □Yes…□No
Are there pets in house □Yes…□No _____ If yes, do the pets sleep with the child □ Yes…□No
Is there any smoking in house (2nd hand tobacco smoke) □Current…□ Past
Home family status: □ Married □ Separated □ Divorced □Joint Custody □ Civil Union □ Foster care
Does your child have special needs? _____

To the best of your knowledge, does your child use the following: Please check (if applicable):

Alcohol use ❑Current ❑past Type/how much?_____
Illicit drug use ❑Current ❑past What drug? _____
Nicotine abuse ❑Current ❑past Type/Packs per day?_____
Caffeine ❑Current ❑past How many cups/glasses/cans per day?_____

Past Medical History: Please check any of the following conditions that apply to your child or your family:

	Child	Father	Mother	Sibling	Grandma	Grandpa	
Alcoholism…….	□	□	□	□	□	□	_____
Arthritis pain…….…….	□	□	□	□	□	□	_____
Asthma…….……..…	□	□	□	□	□	□	_____
Cancer……	□	□	□	□	□	□	_____
Congestive Heart Failure..…	□	□	□	□	□	□	_____
Depression……..…	□	□	□	□	□	□	_____
Diabetes……..…	□	□	□	□	□	□	_____
Emphysema / COPD……..…	□	□	□	□	□	□	_____
Fibromyalgia……..…	□	□	□	□	□	□	_____
Acid reflux…….…..….	□	□	□	□	□	□	_____
Heart attack……..	□	□	□	□	□	□	_____
Heart Arrhythmia……..…	□	□	□	□	□	□	_____
High Blood Pressure……..…	□	□	□	□	□	□	_____
High Cholesterol ……..…….	□	□	□	□	□	□	_____
Narcolepsy ……	□	□	□	□	□	□	_____
Migraine Headache……	□	□	□	□	□	□	_____
Psychiatric problem……..…	□	□	□	□	□	□	_____
Restless Legs…….……	□	□	□	□	□	□	_____
Seizures / Epilepsy…….….	□	□	□	□	□	□	_____
Stroke……..……	□	□	□	□	□	□	_____
Sleep Apnea……	□	□	□	□	□	□	_____
Tuberculosis……..….	□	□	□	□	□	□	_____
Thyroid disease……..….	□	□	□	□	□	□	_____
Other……..……	□	□	□	□	□	□	_____

Past Surgeries: What surgeries has your child had in the past?

Abdominal surgery…….	□_____	___/___/___	Brain/ Head……	□_____	___/___/___
Appendectomy…….	□_____	___/___/___	Heart surgery…..	□_____	___/___/___
Hernia…….……..	□_____	___/___/___	Gallbladder….....	□_____	___/___/___
Ear Tubes …….	□_____	___/___/___	Tonsillectomy….	□_____	___/___/___
Circumcision…….	□_____	___/___/_____	Other……..	□_____	___/___/___

Current medication: Please indicate any vitamins, herbs, and over the counter medications that your child currently takes.

1._____	4._____	7._____	10._____
2._____	5._____	8._____	11._____
3._____	6._____	9._____	12._____

Allergies: List any medication, food, or chemicals which your child is allergic to or has a major side effect to:

1._____	3_____	5._____	7._____
2._____	4._____	6._____	8._____

Allergic to Latex – Yes or No

Review of Symptoms: Check any symptom that applies to your child **at this time**.

Sleep
- ❑ Daytime sleepiness
- ❑ Dry mouth
- ❑ Snore
- ❑ Sore throat
- ❑ Apnea
- ❑ Daytime naps
- ❑ Insomnia

General
- ❑ Night sweats
- ❑ Weight gain
- ❑ Fatigue
- ❑ Weight loss
- ❑ Hot flashes

Eyes / ENT
- ❑ Sinus trouble
- ❑ Difficulty hearing
- ❑ Difficulty seeing
- ❑ Sneezing / watery eyes
- ❑ Nose bleed

Cardiovascular
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Rapid/skipped heartbeats
- ❑ Ankle swelling

Urinary
- ❑ Frequent urination
- ❑ Nighttime urination
- ❑ Urinary incontinence

Musculoskeletal
- ❑ Muscle pain
- ❑ Joint pain
- ❑ Back pain
- ❑ Leg jerks
- ❑ Leg pain with walking

Gastrointestinal
- ❑ Nausea / vomiting
- ❑ Heart burn
- ❑ Irritable bowel
- ❑ Difficulty swallowing

Psychological
- ❑ Depression
- ❑ Anxiety
- ❑ Hallucinations

Pulmonary
- ❑ Chronic cough
- ❑ Coughing blood
- ❑ Shortness of breath
- ❑ Sputum production
- ❑ Wheezing
- ❑ Use of Oxygen

Neurological
- ❑ Memory Loss
- ❑ Dizziness
- ❑ Difficulty walking
- ❑ Difficulty talking
- ❑ Tremors
- ❑ Numbness/tingling
- ❑ One-sided weakness
- ❑ Morning headache

Rate of Pain today 0-10 (0=none, 10=severe) _____ Type of Pain _____ Location of Pain _____

Do you wish your child to be on life support?…….❑Yes….❑No _____

Do you have some one else to make health decisions for you regarding your child in case you were incapacitated ❑Yes…..❑No….. If yes, please list the names of persons who can also make health decisions for your child. _____

_____

Do you wish to add anything else regarding your child's sleep issues?

_____

_____

_____

_____

_____

_____

_____

_____

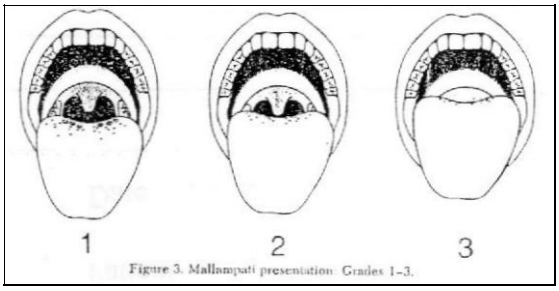
_____

I certify that the above information is accurate to best of my knowledge. I understand withholding information be it intentional, or by negligence to fill out this form, could result in improper medical care and could be a detriment to my health or even life threatening.

_____

Patient/Guardian Signature

For Physician Use Only (Do Not Write Below This Point)

Wt	BP	Neck Circ.	Pulse	Pulse ox	BMI
Allergies:					
CC:					
ROS:  Figure 3. Mallampati presentation: Grades 1–3.					
❑ Education provided					

Sleep Diary

Mark Tafazoli M.D.

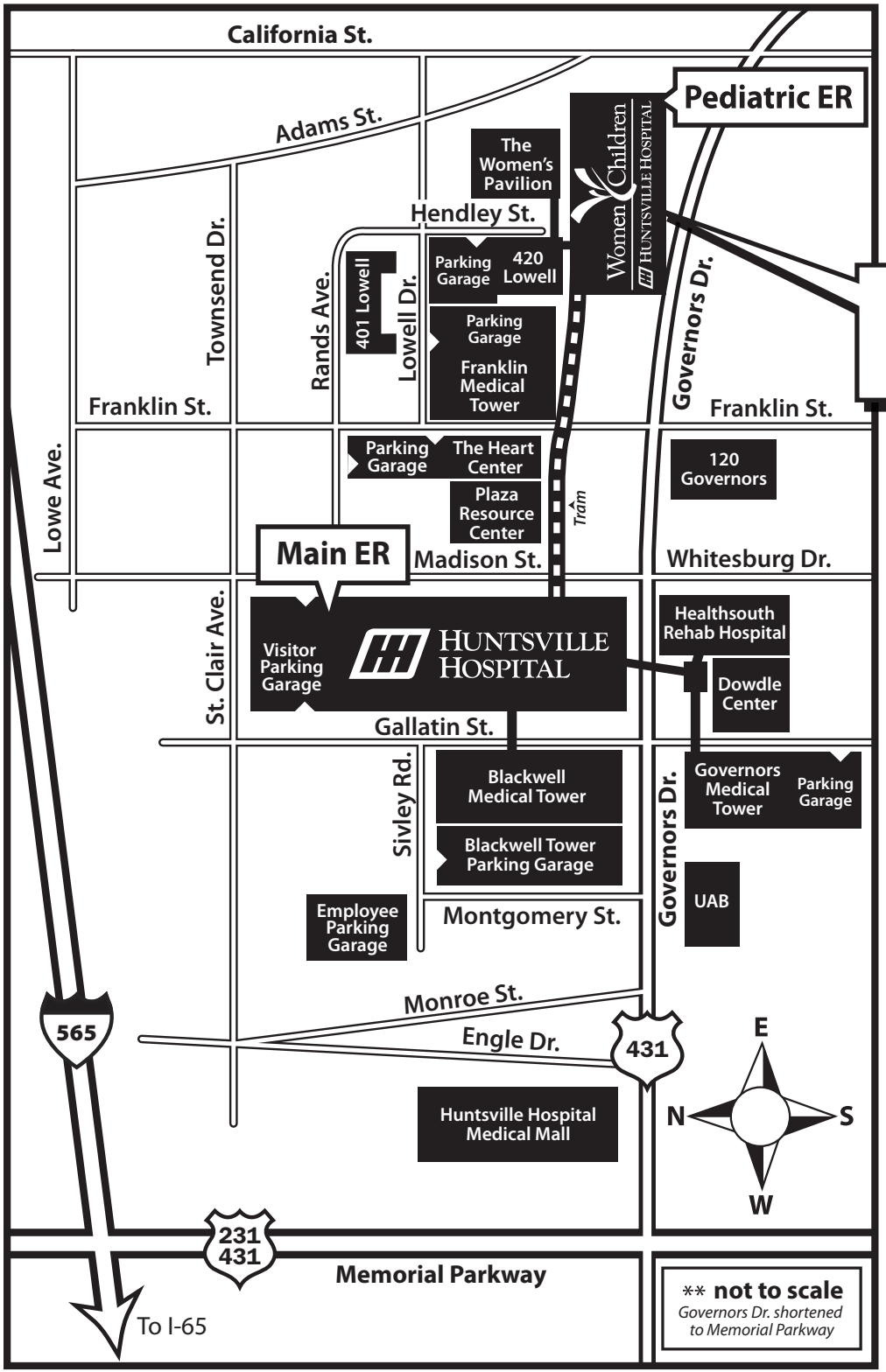
Example of sleep diary as shown bellow:
e.g. sleep time 10:30pm-7am
and 10:30pm – 7am with waking up 3:30-4:30am

example

Date	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am
9/27/08											↓									↑				
9/28/08											↓					↑	↓			↑				

Now please show us your sleep pattern; when you go to bed ↓ ,and wake up and out of bed ↑

Date	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am



HUNTSVILLE HOSPITAL

The Sleep Center
Ground floor
Women & Children Hospital

The Sleep Center is located on the Ground floor of
Huntsville Hospital for Women & Children
245 Governors Dr. SE
Huntsville, AL 35801
(256) 265-8553

Take the elevator in the main lobby to the ground level, turn left when you step off the elevator. We are down the first hallway to the left.