Billings Clinic Miles City Sleep Center

620 South Haynes Ave.

Miles City, MT 59301

Phone: 406-233-7052 Fax: 406-233-7077

Dear Billings Clinic Patient:

We have received a referral to set up an appointment for a Sleep Study and Follow-up, to be performed at our Miles City facility.

Please complete the attached information packet and return to Billings Clinic Miles City.

Most insurance companies require a pre-certification/authorization for some procedures, testing and/or studies. Billings Clinic Miles City will prior authorize your Sleep Study with your insurance company. This does not assure total payment by your insurance company. Billings Clinic does not obtain information regarding your responsibility for Out or Pocket expenses, deductibles, specific procedure, or required facilities for sleep studies associated with your specific insurance plan. It is your responsibility to notify your insurance company prior to your appointment to determine if you will be responsible for a portion of the cost. Your insurance company may ask for CPT codes when inquiring about your portion of the payment. Please reference the following CPT codes if requested by your insurance company:

95810 – Polysomnogram (PSG) or Sleep Study; 95811 – CPAP Titration

The complete sleep evaluation may require 3-4 physician office visits along with 1-2 overnight sleep studies. Depending on your insurance plan, you may be responsible for paying a copay at the time of service for each physician office visit. Sleep studies DO NOT require a copay at time of service. You will receive a statement reflecting the payment due after the completion of the sleep study. The following is an estimated cost for each sleep study prior to insurance or prior payment arrangement: Sleep Study - $3000.00 - $4000.00.

In addition to insurance coverage for your sleep study, your insurance company may cover CPAP/BIPAP machines and /or supplies, according to your plan. Most likely, your doctor will give you a prescription to get a CPAP/BIPAP machine and supplies, depending on the results of your sleep study. As a patient, you have the right to choose any home oxygen and durable medical equipment company that meets your needs.

If you need financial assistance, please contact the Billings Clinic Financial Assistance Program at 406-238-5428 or 406-238-5427. Financial assistance must be arranged prior to your sleep study appointment.

Please sign below to indicate that you understand the above information and that you wish to proceed in scheduling these appointments.

NAME: _____DOB: _____

SIGNATURE: _____

If you have any questions regarding scheduling your appointment or your insurance pre-certification process, please contact our office at 406-233-7052.

Thank you,

Billings Clinic Miles City

PATIENT STICKER

THE EPWORTH SLEEPINESS SCALE

The Epworth sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Write down the number corresponding to your choice in the right hand column. Total you score below.

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (ex: theater or meeting)	
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 a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total Score = _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness.

10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24: You are excessively sleepy and should consider seeking medical attention.

References: Johns MW, A new method for measuring daytime sleepiness: The Epworth Sleepiness scale, Sleep 1991; 14(6):540-5

STOP BANG QUESTIONAIRE

Height _____ inches/cm Weight _____lb/kg

Age _____

Male/Female

BMI _____

Collar size of shirt: S, M, L, XL, or _____inches/cm

Neck circumference _____cm

1. **Snoring**
   Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   Yes No
2. **Tired**
   Do you often feel tired, fatigued, or sleepy during daytime?
   Yes No
3. **Observed**
   Has anyone observed you stop breathing during your sleep?
   Yes NO
4. **Blood pressure**
   Do you have or are you being treated for high blood pressure?
   Yes No
5. **BMI**
   BMI more than 35 kg/m^2?
   Yes No
6. **Age**
   Age over 50 yrs old?
   Yes No
7. **Neck circumference**
   Neck circumference greater than 40 cm?
   Yes No
8. **Gender**
   Gender male?
   Yes No

*Neck circumference is measured by staff

High risk of OSA: answering yes to three or more items

Low risk of OSA: answering yes to less than three items Patient sticker

Adapted from:

STOP Questionnaire A Tool to Screen Patients for Obstructive Sleep Apnea, Frances Chung, F.R.C.P.C.

For Home Sleep Test Only

Home sleep test (HST) for the diagnosis of OSA should be preformed only in conjunction with a comprehensive sleep evaluation (Epworth sleepiness scale, Stop Bang). HST may be used as an alternative to polysomnography in patients with a high pretest probability of OSA.

INDICATION

1. Positive sleep evaluation
2. Snoring
3. Hypersomnolence
4. Suspected sleep related breathing disorders

CONTRAINDICATION

1. Hypoventilation syndrome
2. Moderate to severe pulmonary disease
3. CHF
4. Neuromuscular disease

These comorbidities degrade the accuracy of the study

SLEEP RELATED CONTRAINDICATIONS

1. Central sleep apnea
2. Periodic Limb Movement Disorder
3. Narcolepsy
4. Parasomnia

Home sleep studies do not include the data necessary to diagnose these disorders

-Home sleep studies should not be used for asymptomatic population or general screening

- In house studies remain the Gold standard for polysomnography

Patient sticker

Patient Sticker

Sleep Habits – Please answer questions based on an average night of sleep:

	Bedtime	Time to fall asleep	Wake time	Out of bed time	Approx. sleep duration
Weekdays:	AM/PM	Min	AM/PM	AM/PM	hours
Weekends:	AM/PM	Min	AM/PM	AM/PM	hours

Do you consider yourself a night owl? Yes No

Do you consider yourself a morning person? Yes No

Do you take medication or a supplement to help you sleep? Yes No

Do you need an alarm clock to wake up in the morning? Yes No

How many naps do you take per week? _____ What is the average duration of each nap? _____

Are these naps refreshing? Yes No Do you dream during naps? Yes No

Do you have unusual behaviors during sleep? Yes No

If yes: ___ Nightmares _____Sleepwalking ____Bedwetting _____ Other

Do you grind or clench your teeth at night? Yes No

Have you ever been told by others that you act out your dreams? Yes No

Have you ever felt paralyzed when you first wake up or when you are falling asleep? Yes No

Have you ever experienced episodes of muscle weakness, loss of muscle strength or limp muscles in any part of you body during the following situation: When you laugh Yes No

When you are angry Yes No

When hearing or telling a joke Yes No

Shen tense or under stress Yes No

Have you ever had the sensation of seeing or hearing things when waking up or falling asleep? Yes No

Patient Sticker

RLS – Please circle the appropriate box:

Do you kick your legs at night, prior to or during sleep? Yes No

Do you ever experience a desire to move your legs due to discomfort or disagreeable sensations in your legs? Yes No

Do you sometimes feel the need to move to relieve the discomfort, for example by walking or rubbing your legs? Yes No

Are these symptoms worse later in the day or at night? Yes No

Are these symptoms worse when you are at rest, with at least temporary relief by activity? Yes No

CPAP (for CPAP user only – skip this section if you do not use CPAP):

How many nights per week do you use your CPAP? _____nights/week

How many hours per night do you use your CPAP? _____hours/night

While using CPAP, are any of the following problems present? Circle all that apply.

Snoring	Dry mouth/dry nose	Mask marking the face
Gasping or choking	Stuffy or running nose	Bridge of nose discomfort
Pause in Breathing	Ear pain/ Ear popping	Skin sore or acne from mask
Unrefreshing sleep	Irritating, dry or red eyes	Machine noise Mask Leak

SOCIAL HABITS: Profession/Job: _____

Occupational Status: Actively working Retired Disabled Shift worker

Are you sedentary (no more than 10 minutes of uninterrupted physical activity) during the day? Yes No

Do you exercise for more than 30 minutes at least two time a week? Yes No

Do you smoke habitually or have you ever smoked habitually Yes No

If so, how many cigarettes a day? _____ For how long? _____

If you quit smoking, low long ago did you quit? _____

How many cups of coffee do you drink each day? _____

How many ounces of other caffeinated beverage (ex. Soda, tea, energy drinks) do you drink a day? _____

Do you think you are sensitive to caffeine? Yes No

Do you drink alcoholic beverages occasionally? Yes No Amount _____ # per week/day

Do you drink alcoholic beverages habitually? Yes No Amount _____ # per day

Do you use any recreational drugs? Yes No Decline to answer

Family history – circle all that apply

Sleep Apnea Loud Snoring Restless Legs Narcolepsy

Patient Sticker

Patient Order

Billings Clinic Miles City Sleep Lab
620 South Haynes Ave
Miles City, MT 59301
Phone 406-233-7052
Fax 406-233-7077

Patient Sticker

Diagnosis Codes

	G47.19	Other hypersomnia
	G47.10	Hypersomnia, unspecified
	G47.31	Central sleep apnea
	G47.33	Obstructive sleep apnea
	G47.11	Idiopathic hypersomnia
	G47.61	Periodic limb movement disorder
	R06.83	Snoring

Sleep Study Order

_____ PSG – Split night protocol – 95810

_____ CPAP - 95811

_____PSG – Full Diagnostic – No CPAP trial

_____ PSG – Follow up with CPAP titration – Instructions: _____

_____ Sleeping Aides: Zolpidem per Protocol_____

_____ Portable PSG at Home – 95806TC

_____ Schedule follow up with Respiratory Therapy / RPSGT

_____ Supplemental O_2

Signature: _____ Date: _____ Time: _____