Patient Questionnaire -Post Test

Patient: _____ DOB:_____ Date: _____

What time did you go to bed? _____

Approximate start time? _____

About how long do you think it took you to fall asleep? _____

How many hours do you feel you slept? _____

How does this compare to your normal night of sleep? _____ worse _____ the same _____better

How many times did you awaken last night? _____

Please list the medications that you took during the day: _____

_____

_____

Please list the medications that you took before bed: _____

_____

_____

Did you use a dental device for sleep apnea on this night? Yes No

Patient signature: _____ Date:_____

MUST BE SIGNED

Patient Setup and Education

Patient: _____ DOB:_____ Height:_____Weight: _____

Patient education:

- Discussed sleep apnea with my physician.
- I have viewed the video to learn about use of device and how to apply sensors.
- I understand that I can call 508-796-3227 to have any questions about the use of the device answered by a registered sleep technologist.
- The test is to be returned by 9:30 am the next business day. If you have any questions please call the number on top of the device box.
- You are responsible for the device while it is in your possession. Please be sure to return at the pick-up location unless otherwise arranged.

Patient signature: _____ Date: _____

Device ID:

- All sensors and equipment have been checked and kit is fully equipped: Belt, Cannula, Tape, Instruction sheet, Contact number
- Consent forms completed by patient
- Patient received forms for completion at home: Morning questionnaire, ESS, Instruction guide
- Device prepared for night study with patient indicator

RPSGT signature: _____ Date: _____