Opelousas
GENERAL HEALTH SYSTEM

Sleep Disorders Center
808 North Natchez Blvd.
Opelousas, LA 70570
337-943-7146 Fax: 337-594-3837
Email: sleepcenter@opelousasgeneral.com

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE
SLEEP
MEMBER CENTER

Joseph Y. Bordelon, Jr., MD, D. ABSM
Louis Nix, MD, D. ABIM

You have been scheduled for an appointment on _____ at _____

in the **Sleep Clinic**. During this clinic visit a history and physical will be obtained. Please fill out the enclosed questionnaire, sleep log, and Epworth Sleepiness Scale. Bring these completed forms with you on this visit. A physician will conduct an evaluation by reviewing your history and performing a physical exam. The physician will establish a plan of care. At this time you will be scheduled for any necessary sleep test(s). Please have a detailed list or bring the medications that you are currently taking.

The Sleep Clinic and Sleep Studies are performed at Opelousas General Hospital's Sleep Disorders Center. Please park in the Sleep Center Parking Lot located at 808 N. Natchez Blvd. PLEASE be prompt.

If you have any questions or need to reschedule your clinic visit or test, please call 943-7146 between 8:00 a.m. and 4:30 p.m., Monday through Thursday. After hours you may leave a message and / or call 407-4434 to speak with a night clinician.

Welcome To Opelousas General Health System

Sleep Disorders Center!

We appreciate the confidence and trust you have placed in us and look forward to meeting you personally and professionally.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

- We are truly caring about our patients and want you to feel very comfortable with our entire staff.
- We recognize that each patient is an individual and has individual needs. Our goal is to promote excellence in the diagnosis and treatment of sleep disorders, such as sleep apnea and insomnia.
- We work with only one patient at a time; that time is reserved for you and you alone.
- We strive to be thorough in everything we do, and always attempt to achieve and uphold the standards of care set by the Academy of Sleep Medicine while providing comprehensive, quality centered, cost effective patient care in a compassionate and friendly manner.

As a courtesy to you and **to avoid any financial surprises, we are informing you** that as a patient here, **there will be 2 fees incurred** – one will be the physician fee (call Acadiana Medicine Clinic – 337-948-7090 regarding that fee) and the second will be a hospital facility fee. These 2 fees are usual for outpatient hospital services and are subject to change. Acadiana Medicine Clinic will be billing for Dr. Bordelon and Dr. Nix's services, and OGHS will be billing for the facility fee.

If you have any questions or concerns regarding billing, please contact us at 337-943-7146.

Patient Name: _____ Date: _____

Family Member/Guardian Signature: _____

Relationship: _____ Date: _____

Thank you, and once again, WELCOME!

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NAME: _____ LOCATION: Sleep Disorders Center

I hereby give my consent to be photographed/videoed X _____

I hereby give my consent for _____ to be photographed / videoed

for the following purposes:

1. Educational use
2. Publication in scientific journals
3. Use in the newspaper

X 4 Other: Patient Chart / Sleep Disorders Center

My name or the name of my child may (may not) be used in connection therewith.

Signed: _____

If patient is a minor or unable to sign, person giving consent:

How related: _____

Witness: _____ Date: _____

Physician Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

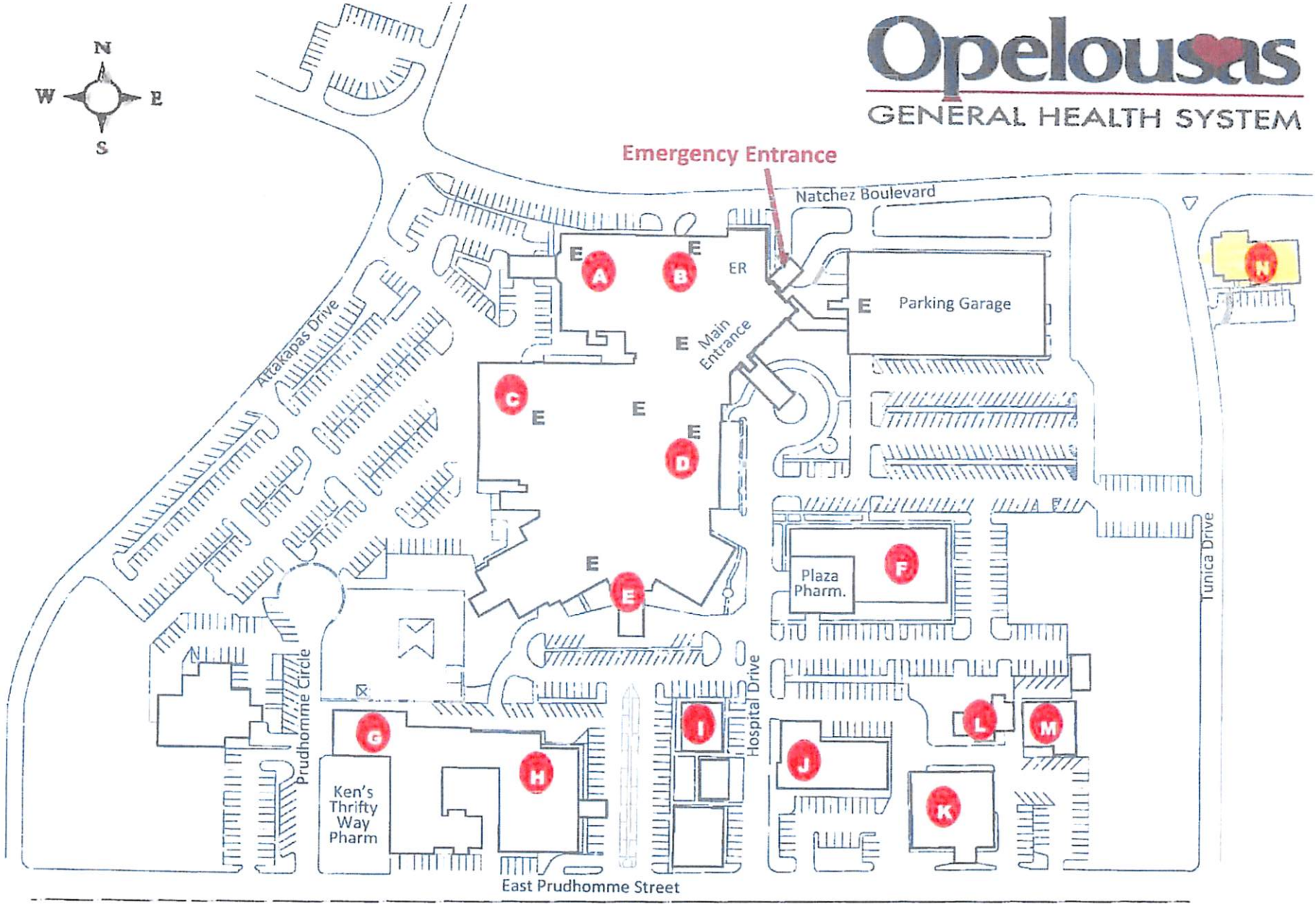
Patient No Show Policy and Timely Arrival to Appointments:

If you are more than **15 minutes** late for your appointment, we will have to reschedule your appointment for a later date. If you are unable to keep your appointment, you are required to cancel your appointment with the appropriate prior notice (24 hours is appreciated). Failure of you to cancel your appointment without a 24-hour notice is considered a "No Show" and you will be charged a **$25.00** fee for purposes of this policy. If **two** or more appointments are missed, then you may be dismissed from our practice. We make every effort to see you in a timely manner and we ask that you respect our time and others' time by arriving in a timely manner.

By signing below, I hereby acknowledge that I understand the above Patient No Show Policy and Timely Arrival to Appointments with the OGHS Sleep Disorders Center.

Patient Name

Date



539 East Prudhomme Street • Opelousas, LA 70570 • (337) 948-3011 • www.opelousasgeneral.com

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OPELOUSAS GENERAL HOSPITAL
SLEEP DISORDERS CENTER

The Epworth Sleepiness Scale

DATE: _____ YOUR AGE (years): _____

NAME: _____ YOUR SEX (male=M; female=F): _____

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

	Chance Of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., a theater or a 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	_____

Thank you for your cooperation

*The numbers for the eight situations are added together to give a global score between 0 and 24. (From Johns MW: A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 14:540-545, 1991.)

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Louis Nix, MD

Sleep Disorders Center Pediatric Questionnaire

Patient Name: _____ _____ _____
Last First Middle

Date: _____ Date of Birth: _____
Month / Day / Year

This is a questionnaire regarding your child's sleeping habits that will help us understand their sleep problems. Please answer the questions in as much detail as possible.

1. Has your child had a sleep problem in the past? ( ) yes ( ) no
2. How long has your child had a problem? _____
3. How would you describe your child's sleep problem? Check all that apply.

( ) Difficulty falling asleep.
( ) Waking up during the night.
( ) Waking up early in the morning.
( ) Difficulty waking up
( ) Excessive daytime sleepiness.

4. How many hours of sleep does your child usually get on average per night?

_____

5. What time does your child usually go to bed on weekdays? _____a.m./p.m. Weekends? ____a.m./p.m.
6. What time does your child usually awaken on weekdays? _____a.m./p.m. Weekends? ____a.m./p.m.
7. Does your child sleep in his own bed? ( ) yes ( ) no
8. Does your child sleep alone? ( ) yes ( ) no
9. Does your child resist going to bed? ( ) yes ( ) no
10. How many minutes or hours does it take your child to fall asleep?

_____

11. How many hours does your child sleep on an average night?

_____

12. How many times does your child wake up during the night?

_____

13. How long is your child up?

_____

14. What wakes your child up?

_____

15. What do you do when your child wakes up during night?

_____

Patient Name: _____

16. Does your child walk or talk in their sleep? Explain:

_____

_____

17. Does your child watch TV, play electronic games, or use a computer while in bed? ( ) yes ( ) no
18. What time does your child stop playing games/computer, watching TV, talking on phone?_____
19. Check the things that apply to your child's daily bedtime routine:

( ) Bath	( ) Prayers	( ) Watching TV
( ) Hygiene	( ) Reading	( ) Light's off

20. Are your child's covers extremely messy in the morning? ( ) yes ( ) no
21. Would you consider your child to be a restless sleeper? ( ) yes ( ) no
22. Does your child wet the bed? ( ) yes ( ) no

    If so, how often does this occur_____
23. Is it difficult to wake your child up and get them going in the mornings? ( ) yes ( ) no
24. Is your child excessively sleepy during the daytime? ( ) yes ( ) no
25. Does your child take naps during the day? ( ) yes ( ) no

    How many times per day? _____

    How long are the naps on average?_____ minutes/hours
26. Is your child having difficulties at school? ( ) yes ( ) no
27. Does your child fall asleep at school? ( ) yes ( ) no
28. Have teachers ever complained about your child being inattentive in class? ( ) yes ( ) no
29. Does your child ever complain of restless legs (inability to keep legs still)? ( ) yes ( ) no
30. How many children are there in the family?_____

31. Do you have any pets living in your house? ( ) yes ( ) no

32. Does anyone smoke in the house? ( ) yes ( ) no

33. Does your child have asthma? ( ) yes ( ) no

34. Does your child snore? ( ) yes ( ) no

35. Have you ever seen your child stop breathing during sleep? ( ) yes ( ) no

36. Have you ever seen your child struggle to breathe while asleep? ( ) yes ( ) no

37. Does your child exercise? ( ) yes ( ) no

38. Caffeine: _____ How many total per day of cokes, chocolate, tea, coffee

39. Smoking: _____ Packs per day

40. Drug use: _____ Marijuana, Cocaine, LSD, etc.

Patient Name: _____

Medications:

Please list the name and amount of medications your child is taking and state how often and why they take each one: (pills, shots etc.)

Name of Medication	Amount	How often	Why

Please list current Pharmacy: _____

41. Does your child have any allergies? ( ) yes ( ) no

Please list: _____

_____

42. Has your child ever had an allergic reaction? ( ) yes ( ) no

Please list to what, and the reaction: _____

_____

43. Please list your child's past medical history.

_____

_____

_____

_____

44. Please list all surgeries that your child has had.

_____

_____

45. Do you have any other comments you would like to make about your child's sleep or wakefulness?

OPELOUSAS GENERAL HOSPITAL SLEEP DISORDERS CENTER

PEDIATRIC CHECKLIST

Patient Name:

WHICH OF THE FOLLOWING APPLY TO YOUR CHILD:	Never	Rarely	Sometimes	Frequently	Always
Awaken from sleep in a "panic"					
Snoring					
Snoring loudly enough to cause others to complain					
Suddenly wake up gasping for air during the night					
Have breathing problems during the night (observed by others)					
Sweat excessively at night					
Excessively fatigued in the daytime					
Fall asleep while reading					
Fall asleep while watching TV					
Fall asleep at gatherings					
Fall asleep during meals					
Fall asleep at school					
Difficulty paying attention in class					
Poor school performance					
Problems with hyperactivity/ADD					
Learning disability					
Autism					
Personality changes or aggressive behavior					
Feel unable to move (paralyzed) when waking or falling asleep (You are awake but cannot move)					
Feel weak when you laugh, get angry, are surprised					
Experience vivid / very real dreamlike scenes upon awakening or falling asleep					
Have nightmares					
Remember dreams					
Feel sad or depressed					
Wake up with morning headaches					
Sleep walk at night					
Talk in their sleep					
Notice parts of their body jerk, especially in the evening					
Kick or twitch during the night, especially in the legs					
Experience pain, crawling, or aching feelings in legs, especially in the evening					
Have morning jaw pain					
Grind teeth during sleep or during the daytime					

Parents Signature:

Date/Time:

OPELOUSAS GENERAL HOSPITAL
SLEEP DISORDERS CENTER

SLEEP LOG

NAME: _____

Please fill out this sleep log every morning about 30 minutes after getting up. Guess the approximate times; do not worry if your figures are not absolutely correct.

DATE:							
1. What time did you go to bed and turn out the lights?							
2. How many minutes did it take you to go to sleep?							
3. How often did you wake last night?							
4. What time did you awake for the last time this morning?							
5. How many hours did you sleep?							
6. Did you feel TIRED or RESTED on awakening?							
7. Did you take any medication to help you sleep?							
8. Did you take any naps during the day?							
9. How many caffeinated beverages did you drink yesterday?							
10. What time did you last drink caffeinated beverages?							
11. Did you have any nightmares?							
12. How much alcohol did you consume yesterday?							