Post Home Sleep Study

Patient Morning Questionnaire:

****This must be filled out and returned when you drop off the unit****

Your referring physician will receive your results when they have been completed. If you haven't done so already, please make sure you schedule your follow up appointment.

If you would like to receive a copy of your sleep study test results, please select one of the following options:

□ **My Chart Message (electronically; must have MyChart account)**

□ **Mail: Please fill out the attached envelope; If not, you may leave the envelope blank**

□ **Fax: Please list fax #_____**

Patient name:_____

Date of birth:_____

Unit #: _____

1) What was the date of study? _____

2) What time did you go to sleep? _____
(*Approximate is fine*)

3) What time did you wake up? _____
(*Approximate is fine*)

4) Did you do study for one or two nights? _____

5) If you did two nights, briefly explain why:

6) If you did two nights, was that ordered from your referring physician?

(please circle one)

Yes No

7) **Did you wear an oral appliance (OA) while using the Home Study Unit?**

(please circle one)

Yes No

If applicable, if you used the unit for multiple nights, please indicate which night you wore the OA and which night you did NOT wear the OA.

Please note: *An OA is **NOT** a device used for Bruxism (teeth grinding), or any other dental issues. The oral appliance we are referring to is one made **SPECIFICALLY** to correct Obstructive Sleep Apnea.*

Please indicate which night you wore the OA and which night you did NOT wear the OA.

Night with OA: _____

Night without OA: _____

8) Are you a current CPAP user? If so, were you able to sleep without CPAP for this test?

9) Did you have any problems/issues with the device? If so, please briefly explain: