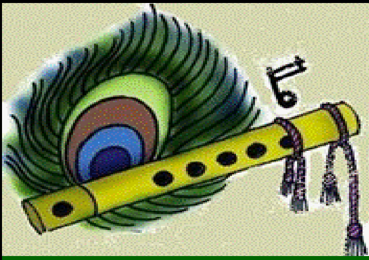

Merrimack Valley Sleep Center, PLLC
Dr. Meena Mehta, M.D.
49 Atwood Road, Suite #3 P.O.Box 155
Pelham, NH 03076
Ph. # (603) 635-7711, Fax: (603) 635-7722

WELCOME TO MERRIMACK VALLEY SLEEP CENTER

Name: ___________________________Date:__________________

Home Address: ____

City/State/Zip: ____

Home Phone: ____________________Cell Phone: ______________

Email Address: ____

Primary Care Physician: ___________________________________

Referring Physician: _______________________________________

Insurance: ____________________________ID#________________

Spouse/ Next of Kin; ______________________________________

How did you hear about us: _________________________________

PLEASE PROVIDE INSURANCE CARD(S)

I authorize payment to be made to Dr. Meena Mehta for any and all services Performed.

Patient Signature: _____________________Date:_______________

I authorize the release of any payment and medical information necessary to process this claim and related claims. I request that payment of authorized medical benefits be made on my behalf for any services furnished by Dr. Meena Mehta. M.D.

Patient Signature: ______________________Date:_______________

Pre-Study Questionnaire

Patient Name: ________________________ Date: ________________________

DOB: ___________________Height: ______________________Weight: ___________________________

Do you have any food or drug allergies? Y/N if yes please explain________________________________

Circle the problems you have tonight:
Sore Throat Congested Nose Cough Fever Headache Muscle or Skeletal Pain

Other Pain or Discomfort (Please
Specify)____
____
____

What time did you go to sleep last night? _______________________________AM/PM

What time did you wake up this morning? ______________________________AM/PM

Please estimate the amount of sleep you had the night before last____________Hours

Did you fall asleep or nap today? YES NO NOT SURE

If you Smoke, What time was your last Cigarette? _______________________AM/PM

What time was your last meal? ____AM/PM

Did you work today? YES NO what Times did you work? ________ To __________

Has today been an unusual day in any respect? YES NO
If so, please explain:
____
____
____

Indicate the beverages you drank today and indicate the amount consumed and time of
day.____

Please list any medications taken in the past 10 days. If you have taken any of these medications in the past 24 hours, please fill in amount and time of day.

MEDICATION	AMOUNT	TIME

Confidential Patient Evaluation of Services

Patient Name: ____

Technologist____

To help us to continue to deliver high quality care, we encourage feedback from our most valuable resource – You, the patient. Please answer the following questions; your comments are sincerely appreciated.

1. How would you rate our facility?
   Bedrooms Excellent Good Average Poor
   Bathrooms Excellent Good Average Poor
   Temperature Excellent Good Average Poor
   Comments____
2. Have you received similar services or tests at another sleep center?
   If yes, where? ____
   How do we compare? Better Same Worse
3. Were you given adequate information by the staff in preparation for your test?
   YES NO
4. Were you seen at your stated appointment time? YES/NO
   If no, Why? ____
5. How would you rate the professionalism of our:
   Sleep Technologists Excellent Good Average Poor
   Office Staff Excellent Good Average Poor
6. Did the technologist speak to you about the purpose of your sleep test? YES/NO
7. If you had a CPAP study, did the technologist give you several mask options and help find the best fit? YES/NO
8. How would you rate the friendliness of our staff?
   Excellent Good Average Poor
9. How comfortable did you feel in the sleep center?
   Very Comfortable a Little Comfortable Not at all Comfortable
10. Would you recommend **MERRIMACK VALLEY SLEEP CENTER** to someone requiring the same service? YES/NO
    Why/ Why Not? ____
11. In your opinion, is there anything we can do to improve our service?
    ____
    ____

Thank you,
Merrimack Valley Sleep Center

Technician Summary Report

Patient Name: ______________________________ Date: ________________________

DOB: ___________________Height: ______________________Weight: ____________________

Referring Physician: ____________________ Primary Physician:___________________________

Medications: ____

Record #_______________________Backup Disk#_________________

Study Type_________________________________PSG Technologist______________________

Lights Out: _________________________________ Lights On: ____________________________

Stages of Sleep 1 2 Delta (3-4) REM

Estimated REM Latency___________________Minutes

Snoring (Loud, Mod, Mild) _________________ Position Dependent (Y N)__________________

Respiratory Events Observed (Circle) OA CA MA H

Frequency (Frequent / Moderate / Occasional)____

Position Dependent (Y N) ____

Oxygen Saturation without CPAP:
Baseline NREM____________________
Baseline REM_____________________
____
Lowest SpO_______________________
SpO_______________

Oxygen Saturation with CPAP
Baseline NREM ___________
Baseline REM
Lowest

PLM'S________________________

EKG Rhythm_______________________________________ EKG Arrhythmias (type)___________

Optimal BiPAP/CPAP Pressure_________________________ Patient Tolerance_________________

Mask Type ____

Comments____

POST STUDY QUESTIONNAIRE

Patient Name: ______________________ Date: ______________________

1. How long after you began to try to go to sleep last night did you fall asleep? (Circle answer below).

   RIGHT AWAY   MINUTES LATER   HOURS LATER   DID NOT FALL ASLEEP

2. Compared to the time it usually takes you to fall asleep, this was:

   LONGER   SOME   SHORTER

3. Altogether, about how long did you sleep _______________ hours?

4. Compared to the amount of sleep you usually get, this was (circle answer below)

   MORE THAN USUAL   LESS THAN USUAL   SAME AS USUAL

5. How much dreaming do you recall?

   NONE   LESS THAN USUAL   SAME AS USUAL

6. How many times do you recall waking up before your final awakening_____________ times

   FOR WHAT REASON (S) ____

7. Compared to the number of times you usually awaken, this was:
   MORE THAN USUAL   LESS THAN USUAL   SAME AS USUAL

8. How did you feel immediately after awakening?
   WIDE AWAKE   SOMEWHAT ALERT   SLEEPY

9. How did you feel 10-15 minutes after awakening?
   WIDE AWAKE   SOMEWHAT ALERT   SLEEPY

10. Would you say the way you slept was:
    BETTER   SAME AS USUAL   WORSE

PATIENTS TESTED WITH CPAP/BIPAP, PLEASE ANSWER QUESTIONS 11-15

11. How well do you feel you tolerated the mask and its pressure?
    POORLY   WELL   VERYWELL
12. Do you feel more refreshed?   YES   NO
13. Did you snore less with CPAP?   YES   NO
14. Would you say the way you slept with CPAP was:
    BETTER   SAME AS USUAL   WORSE (PLEASE EXPLAIN)____
    ____
    ____
    ____

Preliminary Sleep Study Report

The final report will be available in 3-4 weeks

Patient________________________________ **Bed #**______________ **DOB**__________

Referring Physician____________________ **Type of Study**______________________

Date of Study _______________ **Tech**_____________ **Data Base#**_________________

Results:

Recording time: The patient was studied from __________ to _______________

Respiratory:

Breathing during sleep was Normal Abnormal Other________________ The type(s) of sleep-disordered breathing seen were:

Obstructive Hypopnea Central Mixed

Frequency was: Mild Moderate Severe

Events more severe: Supine in REM sleep

Baseline SaO2 was ________% the low was ________%

Snoring was None Mild Moderate Severe

Limb Movements: None Mild Moderate Severe

Cardiac: Normal Abnormal

Types of Arrhythmia____

CPAP or BiLevel pressure _______cm ***H2O Heated Humidity*** C-Flex_____O2____lpm

---

<u>Homecare Company contacted to set up CPAP/BiLevel Therapy:</u>

____None Contacted Mask Brand/Type_______________ Size __________________ Tech

Comments____

____

____

This report represents a preliminary review of the data as collected. A full report is Forthcoming and should be available within 3-4 weeks and will be faxed when available. Call (603) 635-7711 if there are any questions about this patient's results.