

AMERICAN WELLNESS & IMAGING

SLEEP STUDY PATIENT CHECK-OFF LIST

Name _____ **Phone 1** _____ **Phone 2** _____

Appt. Date _____ **Time** _____

Appt. Date – Follow-Up Study _____ **Time** _____
(if this second study is not needed, it will automatically be cancelled.)

DOB _____ **SS#** _____

Insurance _____ **Precert** _____

Study _____ **R/O** _____

_____ Please do not consume any food or beverages containing alcohol or caffeine (including chocolate) after 12:00 noon the day of your appointment. (you can have dinner)

_____ Please wash your face and hair to remove make-up, oils, hairspray, gel, etc. so electrodes will stick.

_____ Please remove all nail polish and acrylic fingernails.

_____ If you take any nighttime medications, please bring them with you.

_____ If you use a nasal spray for congestion, etc., please bring it with you.

_____ Try to avoid dozing or napping the day of your study.

_____ Although pillows are provided, you may bring your own if you prefer.

_____ Please bring loose sleepwear to allow for equipment set up.

_____ The tech will wake you up by 5:30am – 6:00am at which time you are free to go.

_____ Our Sleep Diagnostic Center provides you with a hotel-like atmosphere, quite different from a hospital setting. You're welcome to come by for a tour prior to your study.

_____ We will be mailing you a packet of information and forms. When you receive it, if you have any questions, please don't hesitate to call us.

Primary Care Physician _____

Ordering Physician _____

Appointment was made by: ___PT. ___MD ___INS CO. Scheduler _____ Date _____