GU0606-11/08

CPAP/BiPAP Questionnaire & Patient Assessment to be completed by setup technician

Patient Name:______________________________

1. Have you had a Sleep Study Performed? If Yes, Date performed and Sleep Lab, If No is one pending? Date, Lab.

❑Yes, was on ____/____/______ ❑Home Study ❑No study (stop & schedule with Dr) ❑ Facility based study

AHI / RDI_____________ Who was the doctor that ordered the sleep study? _______________________________

Are progress notes or a History & Physical report on file at the time of setup that indicated reasons why the study was ordered?

❑Yes ❑No *(if no, these notes must be obtained prior to setting up a Medicare patient up on the PAP device.)*

Who was the physician interpreting the study? _________________________

(if a Medicare patient and study was a home study the interpreting Dr must be board certified in sleep)

2. If yes to above question, what type of mask was used in your sleep study CPAP titration, (if titration performed)

❑ Standard Nasal Mask ❑ Full Face Mask ❑ Nasal Pillows System ❑ Other_____________________

3. Do you have frequent problems with stuffed up sinuses or nasal passages. ❑ Yes ❑ No

4. Do you wear either upper or lower dentures? Which? ❑ Upper Dentures ❑ Lower Dentures ❑ None

5. Do you ever experience claustrophobia? ❑ Yes ❑ No

6. Do you ever wake up in the middle of the night and have a very dry throat? ❑ Yes ❑ No

7. Do you sleep with your mouth open? ❑ Yes ❑ No ❑ Not Sure

8. Do you drink coffee, tea, soft drinks during the day? (How many) ❑ Yes #______ ❑ None

9. Do you ever experience dry sinuses or nasal passages? ❑ Yes ❑ No

10. Do you wear eyeglasses and read in bed?

❑ Yes, I wear glasses but do not read in bed ❑ I do read in bed with glasses ❑ No glasses

11. Have you ever been diagnosed with a deviated septum or similar upper airway abnormality? Did you have corrective surgery?

❑ Yes, but have never had surgery for correction ❑ Yes, but had corrective surgery ❑ No

12. Do you often nap during the day? ❑ Often ❑ Occasionally ❑ Seldom ❑ Never

13. Does cold room air while you are sleeping bother you? Which air temperature do you best like to breath?

❑Yes, I prefer warm air at night ❑ No, I like the air to be cold ❑ I prefer a moderate temperature

14. Which sleeping position do us usually use? Most of the time I sleep on my-❑ Stomach ❑ Back ❑ Side

15. Do you have an electrical outlet in the area where you sleep (within 4 feet)? ❑Yes ❑No ❑Have an outlet but not nearby

16. Do you have a night stand or bedside table near your bed or sleeping area? ❑ Yes ❑ No

Medicare patients only:

17. Patient has received instruction about having PAP downloaded and a physician follow up visit performed between the 31st and 91st day of therapy to ensure continued coverage of PAP therapy. ❑ Yes ❑ No

Follow up in our office set for ______________ Physician Follow up appointment set up for_________________
(if an appointment has not been set with the physician at the time of setup, inform the patient that one is required; instruct them to set an appointment date with their prescribing physician as soon as possible. Coordinate care with the physician's office by letting them know that the patient must have a follow up visit between the 31st and 91 th day following setup preferably in the 5 weeks).

18. Patient has been instructed on how to download data to smart card? ❑Yes ❑No ❑ Patient will come in date above

19. Patient is aware that they must use equipment a minimum of 4 hours per night 21 out of 30 days during the initial 12-week period and has been given an applicable compliance letter? ❑Yes ❑No *(if no mail the patient a letter immediately)*