Sleep Associates of Connecticut
the sound sleep center

Michael Imevbore, MD FCCP
Pulmonary Critical Care
and Sleep Medicine

West Haven • 203.909.6950
687 Campbell Avenue West Haven, CT 06516

Hamden • 475.202.6512
2543 Dixwell Avenue Hamden, CT 06514

Permission To Photograph And /Or Record Audio And Video

I, _____,
Patient/Guardian

hereby authorize Sleep Associates of CT (SAC), or their representative, to take photograph(s) and/or record audio and video. I understand that such photograph(s), audio recording(s) and/or video recordings may be used for clinical or educational purposes or in the event of legal action. The sleep center and trustees of SAC and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings.

The undersigned also hereby transfers and assigns to the SAC the right to copy the materials in whole or in part. No use of the material for educational purposes will identify me by name.

☐ Check here if you do NOT authorize use for educational purposes.

_____ _____
Signature (patient or guardian) Date

Relationship to Patient if Guardian _____

_____ _____
Witness Date

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A. Joel Papowitz, MD
Diplomat, American Board of Sleep Medicine

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Consent For Polysomnography

Details

A polysomnogram is an overnight sleep study. It records detailed information that shows how your body acts while you sleep. A technician will attach sensors to your body for the study. The sensors will keep track of these body functions:

- Brain waves
- Heart rate
- Breathing rate
- Oxygen level
- Eye movements

The study also may involve other sensors. The sensors send signals to a computer. The sleep center will use this information to prepare a detailed report about your sleep. The doctor who sent you to the sleep center will receive a copy of this report. He or she will then discuss the results with you.

Risks

There is no major health risk involved with this sleep study.

Agreement

My signature below indicates that I understand and agree with the following statements:

1. This sleep study may not detect the cause of my sleep problem.
2. A technician will attach sensors to my body for the study.
3. These sensors may smell bad when they are placed on me.
4. The removal of the sensors in the morning may irritate my skin and cause redness.
5. A video camera will record me as I sleep. A technician will watch me on a monitor in the control room.
6. I will be free to roll over and move in bed during the study.
7. I will need to ask for help if I must get out of bed for any reason.
8. The technician may need to enter the room to wake me if there is a problem.
9. The study may show that I stop breathing many times during the night. If this happens, a technician may enter my room to give me treatment. This treatment is called positive airway pressure, or PAP. To use this treatment, I will wear a mask that covers either my nose or my nose and mouth.
10. I understand why I am taking this sleep study.
11. The sleep center staff explained this sleep study to me. I understand what is going to happen during the study.

_____ _____

Signature (Patient or Guardian) **Date**

_____ _____

Signature (Witness) **Date**

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BEDTIME QUESTIONNAIRE

Patient Name: _____ Date: _____

How long did you sleep last night? _____ hours

Did you take a nap today? _____ At what time? _____ For how long? _____

Prior to coming to the sleep center, has today been unusual in any way?

_____

_____

_____

Did you have any of the following today?

- ❑ Alcohol What time? _____ How much? _____
- ❑ Coffee What time? _____ How much? _____
- ❑ Tea What time? _____ How much? _____

What medications have you taken today?

Medication	**Amount**	**Time Taken**

Do you have any physical complaints right now? If yes, please explain:

_____

_____

Usual bedtime: _____a.m./p.m. Usual wake time: _____a.m./p.m.

Name: _____ **Date:** _____

1. Take the time to fill out this form for last night's sleep when you get up to start your day. **(No need to watch the clock, just estimate sleep time or time awake).**
2. You will indicate **what time you actually began trying to fall asleep** by drawing a down arrow. ↓
3. You will indicate **what time you got up to start your day** with an up arrow. ↑
4. Shade the boxes showing **when you think you were sleeping**. example: 
5. If you are awake for more than half an hour, leave that area un-shaded.
6. **In the morning**, under the "rested" column, mark how rested you felt upon arising, on a scale of 1-7, ***1 being most rested.***
7. **In the evening**, under the "sleepy" column, mark how sleepy you felt for most of day, on a scale of 1-7, ***7 being most sleepy.***
8. Before you go to bed indicate by letter what times you took (M)edication, (C)affeine (# of beverages or chocolate pieces), or (A)lcohol (# drinks, beers, or ounces), and shade in time for any naps that day (Note: use M1, M2 etc for different medications).

		Afternoon							Evening				Nighttime								Morning					
Today's Date	Sleepy?	12 pm	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	Rested?