Patient Checklist

Name: _____ Date of Test: _____

_____ Patient called _____ Left message

Prior test? ☐ Yes ☐ No At this facility? ☐ Yes ☐ No

Patient's normal bedtime is: _____

Patient is diabetic? ☐ Yes ☐ No

Patient takes the following sleep medications: _____

Does the patient need assistance with any of the following?

Walking ☐ Yes ☐ No

If yes, (assistance of 1 person or 2) _____

Do you use an assistive device? ☐ Yes ☐ No Cane or walker?

_____

Bathroom use? ☐ Yes ☐ No

If yes, (assistance of 1 person or 2) _____

Getting in and out of bed? ☐ Yes ☐ No

If yes, (assistance of 1 person or 2) _____

Getting dressed and undressed? ☐ Yes ☐ No

If yes, (assistance of 1 person or 2) _____

Patient reports the following special needs: _____

Patient reports the following about their sleep: _____

Allergies? ☐ Yes ☐ No Adhesive? ☐ Yes ☐ No Latex? ☐ Yes ☐ No

Height: _____ Weight: _____

Patient sleeps flat, elevated, # of pillows? _____

_____ Insurance verified Need auth? ☐ Yes ☐ No Date faxed: _____

_____ Progress note (any prior test?)

_____ Referral completed

_____ Order sent to be signed