



# 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