5850 Coral Ridge Dr. Suite 304 Coral Springs, Florida 33076
PHONE: (877) 337-7111 FAX: (866) 677-4465 WEB: www.virtuox.net

Dear Patient,

Enclosed you will find the equipment for the Home Sleep Testing and documents for you to fill out.

Home Sleep Test Delivery Ticket / AOB which you will need to sign along with the date that you took the test and place back in the box to be returned to us.

Home Sleep Testing Instructions / Information Guide that gives you step by step instructions on the use of the equipment and a phone number for you to call if you have any difficulties.

Sleep History / Patient Questionnaire that needs to be filled out as much as possible. This will aid the Sleep physician in determining a proper diagnosis.

Once you are done with the test place the equipment back in the same box along with the signed copy of the **Home Sleep Test Delivery Ticket / AOB** and the **Sleep History / Patient Questionnaire.**

Find the prepaid postage slip from inside the box and replace the one on top with the new one.

Put box in your normal outgoing mail for return to VirtuOx.

If you have any questions please feel free to contact us at (877) 337-7111.

Thank you,

Virtuox, Inc.
Home Sleep Testing
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Coral Springs, FL 33076
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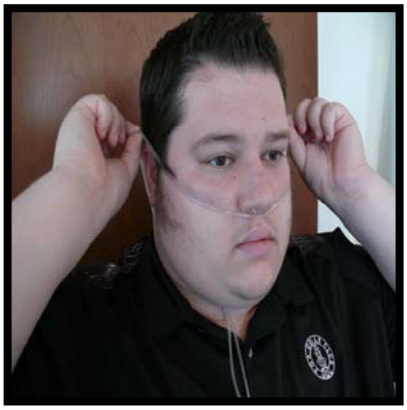
Home Sleep Test Instructions

Step 1: Apply the Effort Sensor (Belt)
Wrap belt around your body between your chest and abdomen.
Pull straps on each side of belts in order to make a snug fit



Step 2: Apply the Airflow Sensor

Place the nasal pressure sensor above the upper lip with the prong protruding slightly into the nostrils.
Run the sensor tubes behind your ears
Adjust the choker located on the tube below the chin, to make sensor snug to face

Step 3: Apply the Oximeter Sensor
Align the Finger Clip sensor so it lines up with fingernail.
Note: The top of the sensor has a wire coming out of it. Slide the Finger Clip sensor on your finger until the LED inside the top is directly above the middle of your nail bed. Lightly squeeze the sensor to ensure that there is a snug fit.
Note: Do not wrap tape around the sensor. It is held in place by an internal spring which provides tension.

Step 4: Turn on the Recorder

Turn on Home Sleep Testing unit by depressing the button showed to the left until the green light comes on.
Note: After the unit is on the small green light will flash occasionally. The light will dim after 10 minutes but the ApneaLink continues to record.

In the morning, depress the button showed to the left 3 times in succession to turn off ApneaLink. The small green light will illuminate and turn off.

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Home Sleep Test Information guide

Your physician has ordered you a Home Sleep Test (HST) to evaluate if you have a life threatening disorder called Sleep Apnea.

Some of the symptoms of Sleep Apnea are:

- Snoring
- Daytime sleepiness
- Foggy or not alert
- Depression
- Poor concentration.

Some of the prevalence of Sleep Apnea

- 80% of Drug Resistant Hypertension
- 50% of Congestive Heart Failure
- 50% of Atrial Fibrilation
- 35% of Hypertension
- 77% of Morbid Obese
- 50% of Diabetes

If left untreated Sleep Apnea can cause Hypertension, Diabetes, Heart Failure, Stroke and death.

Medicare recently approved in Home Sleep Testing. Since most insurances companies follow Medicare guidelines, you now have access to this procedure in the comfort and privacy of your home.

Instructions to follow:

- Unpack your Home Sleep Test unit from the case
- Find the return label / return postage in box. Place this on outside of box over the old shipping labels.
- Do not throw away the box the device came in, as you will use this box to ship the device back
- Go to bed at your normal time, follow instructions on reverse side.
- Put all sensors on your body as outlined on following page
- If you have to get up for the restroom, please leave on sensors and push the purple button.
- Make sure there are NO AMBER flashing lights during fitting and adjust according to instructions.
- When you wake up the next morning, pack up your Home Sleep Test unit in the box provided
- Put box in mail for U.S mail carrier to return back to Virtuox

Note: The following will take 7-10 business days to process

- Once unit is returned we will score the data on the device
- We will then send your test results to one of our Board Certified Sleep Physicians for them to Interpret
- After Interpretation, we will forward your results back to your primary physician
- Your primary physician will discuss your results with you at this time
- Your physician may order you a CPAP or breathing machine to treat your Sleep Apnea

Remember, we are available through out the night to answer any of your questions.

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Home Sleep Test
Delivery Ticket / AOB

Patient Information:

Name: _____ Sex _____ DOB: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone:_____ Diagnosis: _____

Diagnostics:

___Level III Home Sleep Test (CPT G0399) Date of Service: _____

___Level IV Home Sleep Test (CPT G0400) Date of Service: _____

Assignment of Benefits:

The undersigned, understand and agree that the home sleep test just performed or that I am about to perform was ordered for me by my physician for the purposes of verifying if I have Sleep Apnea. I hereby authorize Virtuox to bill my insurance carrier or Medicare on my behalf for the costs of this test. I understand that I may be financially responsible for a deductible or co-pay and agree to make such payment if it is determined that my deductible or co-payment has not been met at the time of billing. If I am deemed ineligible by Medicare or other insurance carrier to which Virtuox submits a claim on my behalf, then I agree to pay a one time fee of $300.00. I certify that I am the recipient of the testing described herein and that the test was actually performed on me. An informational sheet was left with me containing instructions on how to perform the test, as well as contact information for Virtuox in the event that assistance was needed. I hereby authorize Virtuox to release information concerning this test and any medical information necessary to the provider(s) of my medical care.

_____ _____ _____

Test Date Patient Signature Signature Date

SLEEP HISTORY
(TO BE COMPLETED BY PATIENT)

Name: _____Social security number: _____ Date: _____

Spouse or emergency contact(s): _____

Send copy of results to (e.g., family physician, internist): _____

CHIEF COMPLAINT

Check any of the following that apply:
____Loud snoring
____Breathing or snoring stops for brief periods in my sleep
____Awaken gasping for breath
____Do not feel restored when I awaken

My MAIN sleep problem has bothered me:
[ ] 1 to 2 years
[ ] longer than 2 years
[ ] several months to 12 months
[ ] within the last 3 months
[ ] within the last month

I become sleepy during the day (please circle any/all that apply)
____sitting
____riding
____driving
____ reading
____talking
____eating
____standing

I experience the following:
____Difficulty falling asleep
____Difficulty remaining asleep
____Awaken too early

SLEEP TREATMENT

I was previously diagnosed with:
___Sleep apnea When? _____ Where? _____

My prior treatment included:
____CPAP or BiPAP or Bilevel
Indicate treatment level (if known)_____
____Oral appliance
____Sinus, deviated septum or turbinate reduction
____Uvulopalatopharyngoplasty
____Laser or other procedure on uvula
____Mandibular surgery
____Tonsils and/or adenoidectomy

___Restless legs syndrome
When? _____ Where? _____ Treatment: _____

___Periodic limb movements
When? _____ Where? _____ Treatment: _____

___Narcolepsy
When? _____ Where? _____ Treatment: _____

___Insomnia
When? _____ Where? _____ Treatment: _____

SYMPTOMS DURING SLEEP

Indicate ON AVERAGE how often you experience the following symptoms especially when sleeping or trying to sleep:

Times per week

None	1-3	4-6	Daily	Symptom
				My mind races with many thoughts when I try to fall asleep
				I often worry whether or not I will be able to fall asleep
				Fatigue
				Anxiety
				Memory impairment
				Inability to concentrate
				Irritability
				Depression
				Awaken with a dry mouth
				Morning headaches
				Pain which delays or prevents my sleep
				Pain which awakens me from sleep
				Vivid or lifelike visions (people in room, etc) as you fall asleep or wake up
				Inability to move as you are trying to go to sleep or wake up
				Sudden weakness or feel your body go limp when you are angry or excited
				Irresistible urge to move legs or arms
				Creeping or crawling sensation in your legs before falling asleep
				Legs or arms jerking during sleep
				Sleep talking
				Sleep walking
				Nightmares
				Fall out of bed
				Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
				Bed wetting
				Frequent urination disrupting sleep
				Teeth grinding
				Wheezing or cough disrupting sleep
				Sinus trouble, nasal congestion or post-nasal drip interfering with sleep
				Shortness of breath disrupting sleep

SLEEP HABITS

Please answer the following questions as accurately as possible. Indicate AM and PM. If your work and/or sleep schedule changes during the week then indicate your schedule using the "shift work" column.

Activity	Usual schedule	Weekends	Shift Work
Lights out			
I usually fall asleep in (minutes, hours)			
How many times do you awaken each night?			
Number of times you have difficulty returning to sleep			
The total time I spend awake in bed			
I usually wake up from sleep at			
What time do you usually get out of bed from sleep?			
How many hours of sleep do you get on average?			
Do you take naps and, if so, for how long?			
Begin work time			
End work time			

If you do rotating shift work, or have other work schedule changes and need more space to describe:

MEDICAL HISTORY

Please check if you have had any of the following:

( ) Heart disease List type: (e.g., CHF)_____ ( ) Diabetes ( ) Depression
( ) High blood pressure ( ) Asthma/Emphysema ( ) Reflux ( ) Thyroid condition
( ) Fibromyalgia ( ) Anxiety ( ) Seizures ( ) Parkinson's disease
( ) Stroke ( ) Head Injury or brain surgery ( ) Other _____

( )Pain which disrupts sleep. The typical location(s) for this pain is/are:
___Headaches ___Neck ___Back ___Chest ___Limb (arm(s) or leg(s))
___Abdominal ___Pelvic ___Joint (arthritis)

( ) Other medical problems which may affect sleep (please list):_____

HEIGHT and WEIGHT

What is your height? _____ feet and _____ inches
What is your weight? _____ 1 year ago _____ 5 years ago _____
What is your collar size? _____ 1 year ago _____ 5 years ago _____

MEDICATION

Do you take anything to help you sleep? Y/N What?_____ How often?_____

List current medications and dosages, including both prescriptions and over-the-counter medications:
_____
_____

Are you on supplemental oxygen? Yes___ No ____ If yes, how much? _____(Liters/min)

SOCIAL HISTORY

Do you smoke? _____ Did you previously smoke? _____
How many years of smoking? _____ How much per day? _____
Do you drink alcohol? _____ How much? _____ drinks per (day/week/month) (please circle)
Do you use drugs recreationally? _____ If yes, what do you use? _____
How much caffeinated coffee, tea or cola do you drink daily? _____
What is your occupation? _____
What do you usually do at work? _____
What is your level of education? _____

ENVIRONMENT

Is your bedroom (loud/quiet) and (light/dark)? (please circle)
Is your mattress (soft/hard/just right)? (please circle)
Do you go to sleep with the television on? Yes ___ No ___
Is your sleep disturbed because of your bed partner or others in your household (children or pets)? Yes ___ No ___

FAMILY HISTORY (Please check all that apply)

Is there a family history of:	Apnea	Snoring	Narcolepsy	Insomnia	Restless Legs Syndrome	Other sleep disturbances
Mother						
Father						
Sister(s)						
Brother(s)						
Grandparent(s)						

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation.

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

Situation	*Chance of Dozing*
Sitting and reading ……	_____
Watching TV ……...	_____
Sitting, inactive, in a public place (e.g., a theater or a meeting) ……..	_____
As a passenger in a car for an hour without a break ……	_____
Lying down to rest in the afternoon when circumstances permit ……	_____
Sitting and talking with someone ……	_____
Sitting quietly after a lunch without alcohol ……	_____
In a car, while stopped for a few minutes in traffic ……	_____
Total	_____