Regions Hospital®
HealthPartners®

Sleep Health Center

You have been scheduled for an Insomnia Treatment Program consultation to discuss your sleep.

Enclosed you will find four documents: the **CBT-I Questionnaire**, the **Informed Consent Checklist for Telepsychology Services**, an instruction sheet for installing Google Duo, and instruction for signing up for MyChart. In order for us to be able to conduct your initial appointment, you must complete the first two forms and return them to the specialist you will be seeing for your appointment. You should have this done the day before your appointment.

If you are scheduled to meet with Dr. Blackburn, email both forms to Richard.A.Blackburn@HealthPartners.com.

If you are scheduled to meet with Dr. Davig, email both forms to James.P.Davig@HealthPartners.com.

Also, be sure to have downloaded the Google Duo app to your smartphone, tablet, laptop, or desktop computer.

Activating your MyChart function will allow us to communicate our instructions and recommendations to you in a way that you can access.

We look forward to helping you to improve the quality of your sleep, and thank you for taking the time to complete this information.

APPOINTMENT INFORMATION:

DATE:_____

TIME:_____

LOCATION: You will be contacted using the Google Duo app on your smartphone, tablet, laptop, or desktop computer.

PHONE: 651-254-8150

FAX: 651-481-4951

CBT-I Questionnaire

(Right click and highlight
for the yes/no questions)

Name:_____ DOB:_____ Today's Date:_____

Address:_____

Marital Status: Single Married Divorced Separated Widowed Partnered

Children's names/ages: _____

_____

People living with you: _____

Where were you born?_____Where were you raised? _____

What schools have you attended? _____

Are you currently a student? Yes No If yes, what school? _____

Are you employed? Yes (Full-time Part-time Temporary) No

Current or most recent occupation:_____

Do you use: **Tobacco** No Yes **Caffeine** No Yes
Alcohol No Yes **Recreational drugs** No Yes

How many days per week do you engage in formal exercise? 0 1 2 3 4 5 6 7

How satisfied are you with your social support? (0=not happy; 10 = very happy) /10

Have you ever had an overnight sleep study? Yes No Do you currently use CPAP or an oral appliance? Yes No

Have you ever seen a psychiatrist, psychologist, therapist, or counselor? Yes No

Are you currently seeing a psychiatrist, psychologist, therapist, or counselor? Yes No Have

you ever been hospitalized for psychiatric or emotional problems? Yes No

Have you ever been treated for chemical dependency or abuse? Yes No

Please describe how much distress you have been experiencing in the past week including today:

(***None***) 0 1 2 3 4 5 6 7 8 9 10 (***Extreme***)

What recent stressors are you dealing with? _____

Length of current sleep problems: 0-3 months 3-12 months 1-5 years 5-10 years 10-20 years > 20 years

Were there any specific events/causes that you are aware of? _____

_____

Are the sleep problems: getting worse stable/not changing recently improving episodic

Are you aware of a family history of sleep problems? _____

Sleep Habits (answer these questions based on the past 3 months, with "night" meaning your usual sleeping time)

What are you typically doing **before** getting into bed:_____

What time do you typically **get into** the bed on weekdays or days that you work?_____AM PM

How many nights per week do you have difficulty *falling* asleep? 0 1 2 3 4 5 6 7

How many minutes until you are asleep **after getting into** your bed? 0-5' 5-20' 20-60' 60-120' 120-240' >240'

What are you doing while in the bed? (TV read listen to music/podcasts eat text work phone use computer use)

After first falling asleep, how often do you wake up and fall back to sleep? 0-1x 2-3x 4-5x 5-10x >10x

How many <u>total</u> minutes are you awake, as a result of your awakenings? 0-5' 5-10' 10-30' 30-60' 60-120' >120'

What do you do when awake in the middle of the night? (read TV music eat work phone/computer lay in bed)

What types of things wake you up? _____

How many mornings do you wake up too early and have difficulty returning to sleep? 0 1 2 3 4 5 6 7

What else do you do when this happens? (read TV music eat work phone/computer stay in bed)

What time do you typically **get out of** bed to start the day?_____AM PM

Do you keep a regular sleep schedule? Yes No Is your sleep schedule different on week-ends? Yes No

How would you rate your sleep quality on a scale of 0-10? (0=lowest quality and 10=highest quality):_____/10

How much does poor sleep impair your daily functioning? (0= none, 10=completely impairs me):_____/10

How many days per week do you take a nap: 0 1 2 3 4 5 6 7 Typical nap length: _____

Do you currently do shift work? Yes No Have you done shift work in the past? Yes No

If you could set your own sleep schedule: What time would you go to sleep?_____am pm

What time would you get up? _____am pm

Please list all prescription sleep medications you are taking: _____

_____

Please list anything else you take to help your sleep: _____

How many nights per week do you use a sleep medicine?_____Is your sleep disrupted by your bed partner? Yes No

What sleep medications have you taken in the past? _____

Is your bedroom: Dark Cool Quiet Comfortable bed Do you feel safe and secure where you sleep? Yes No

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 = No chance of dozing 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, i.e., a theater or 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 to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car stopped for a few minutes in traffic	_____
TOTAL:	_____

Insomnia Severity Index

For each question, please circle the number that best describes your answer.
Please rate the current (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	0	1	2	3	4
Difficulty staying asleep	0	1	2	3	4
Problems waking up too early	0	1	2	3	4

How **SATISFIED/DISSATISFIED** are you with your **CURRENT** sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

How **NOTICEABLE** to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

How **WORRIED/DISTRESSED** are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, mood ability to function at work/daily chores, concentration, memory, mood, etc.) **CURRENTLY**?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

WHODAS 2.0 World Health Organization Disability Assessment Schedule 2.0

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

		1	2	3	4	5
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example: festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometer (or equivalent 6/10ths of a mile)?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

TOTAL:_____

H1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days _____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days _____
H3	In the past 30 days, not counting the days that you were totally unable, for many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days _____

INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting telemedicine sleep services, I was informed and agreed to the following:

1. I understand that at present telepsychology is the only option for insomnia CBT-I care and I wish to engage in this service.

2. I received information on how the video conferencing technology will be used and that I will not be in the same room as the provider.

3. I understand that my healthcare information may be shared with others for scheduling and billing purposes.

4. I understand that the potential risks and benefits of video conferencing (e.g. limits to confidentiality, technical problems, unauthorized access) and that these differ from in-person sessions.

5. Confidentiality and its limits still apply to telepsychology services, and nobody will record the session without permission from the other person(s).

6. We agree to use the Google Duo video-conferencing platform and I was given information on how to use it with my intake packet. I will download it from my app store prior to my appointment.

7. I understand that I will need to use a webcam or smart phone with camera during the session.

8. I understand that I am encouraged to use a secure internet connection rather than public/free Wi-Fi.

9. I agree to be available on-time for these sessions, and that if I need to cancel or change the tele-appointment, I must notify the sleep center 24-hours in advance by phone or email.

10. If I am not 18-years of age, my parent or legal guardian will sign this form in order for me to participate in these services.

11. I understand that some insurances may not cover telepsychology services and it is my responsibility to verify with my insurance company that telepsychology will be reimbursed. If they are not covered by the insurance company, I will be responsible for full payment.

12. I understand that Dr. James Davig is licensed to practice in Minnesota, and that Dr. Blackburn is licensed to practice in Minnesota and Wisconsin. I agree that I will be physically located within the state the provider is license at the time of the service, and I will provide my physical address at the start of the appointment.

13. If video conferencing services are disrupted, I can be reached at the following phone number. _____. If that isn't possible, the session will need to be rescheduled.

14. I agree that in the advent of an emergency, I have an emergency contact named in my medical records and I grant permission to contact them.

15. The closest Emergency Room to my location is _____, and if I need emergency care, I will be sent to that location.

By signing this form, I certify that:

1. I have read or had this form read and understand its contents. I will contact Regions Sleep Health Center at 651-254-8150 if I have questions.

2. I hereby release Health Partners, RHSC, Inc., and Regions Hospital, its personnel and any other person participating in my care from any and all liability that may arise from unauthorized access to our telepsychology session.

Patient's Name/Signature Date

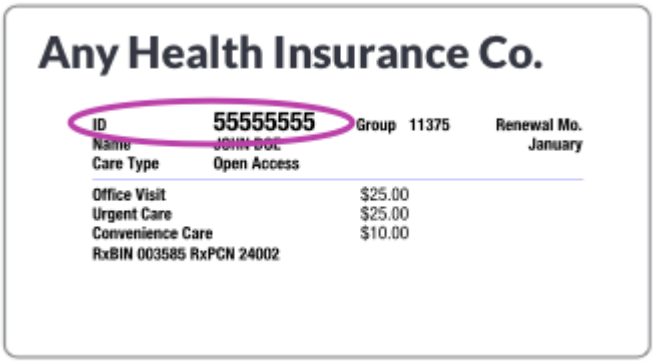
Psychologist's Name/Signature Date

How to Sign up for My Chart

Go to:

https://www.healthpartners.com/account/create

All you need is the ID number on your insurance card. Any type of health insurance is OK.



Click the “Get Started” button and fill in all fields for “About You”, “Security” and “Finish Up”.