920 Copperfield Blvd, NE
Concord, NC 28025
Phone: (704) 707-4120
Fax: (704) 706-9520

CAROLINAS SLEEP SPECIALISTS
Daniel T. Garber, M.D.

Your Sleep Study is scheduled for: _____. Please arrive at Carolinas Sleep Specialists at ____ pm.

We are located at: 920 Copperfield Blvd, NE Concord, NC 28025

**Be prepared to pay your $_____ copay and/or $_____ deductible.
**Bring your driver's license and insurance card.

1. Please do not drink any caffeine or alcohol after 3:00pm. No smoking for 1hr before arrival.
2. DO NOT use any face or body moisturizers, hair spray or gel prior to your study.
3. If you are on oxygen at home, please let us know before coming in for your appointment so that we will have it available at the time of your study. Also, if you use a CPAP machine, BIPAP machine or have any kind of a handicap please let us know.
4. Patients are required to wear appropriate sleepwear. Bring shorts, jogging pants or pajamas to sleep in. You may bring your own pillow and something to read if you wish. (Magazines, TV with Netflix and Hulu are also available in each room).
5. Please bring your own toiletries, i.e. toothpaste, comb, etc.
6. Please bring and take all medications as usual. We do not provide any medications, prescribed or non-prescribed. **This includes any kind of sleep aid.**
7. Wake up time is approximately 5:30-6:00am. YOU WILL BE LEAVING BY 7:00am.
8. Patients with nutritional needs (diabetes, etc.) should bring necessary snacks.
9. Your test results will be sent to your referring physician a few days after your sleep study.
10. A 48 hour cancellation notice is required or a $75.00 setup fee will be charged. Please note: Insurance will not cover this charge.

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Bed Partner Sleep Questionnaire

Please answer the following questions to the best of your ability, noting any unusual behavior during sleep.

Name of patient: _____Date:_____

Name of person filling out form: _____Date: _____

Relationship to the patient: _____

Have you witnessed your bed partner? Circle Yes or No below…

1. Snoring: Yes No
2. Gasping for breath while asleep: Yes No
3. Stop breathing during sleep: Yes No
4. Suffer from morning headaches: Yes No

Has the patient ever fallen asleep during normal daytime activities or in a dangerous situation? If yes please explain:

_____

_____

_____

Please describe any sleep behaviors you have observed in detail. Include a description of the activity, the time during the night when it occurs, frequency and whether it happens every night:

_____

_____

_____

_____