

**Opelousas**  
GENERAL HEALTH SYSTEM

Sleep Disorders Center  
808 North Natchez Blvd.  
Opelousas, LA 70570  
337-943-7146 Fax: 337-594-3837  
Email: [sleepcenter@opelousasgeneral.com](mailto:sleepcenter@opelousasgeneral.com)



Joseph Y. Bordelon, Jr., MD, D. ABSM  
Louis Nix, MD, D. ABIM

You have been scheduled for an appointment on \_\_\_\_\_ at \_\_\_\_\_

in the **Sleep Clinic**. During this clinic visit a history and physical will be obtained. Please fill out the enclosed questionnaire, sleep log, and Epworth Sleepiness Scale. Bring these completed forms with you on this visit. A physician will conduct an evaluation by reviewing your history and performing a physical exam. The physician will establish a plan of care. At this time you will be scheduled for any necessary sleep test(s). Please have a detailed list or bring the medications that you are currently taking.

The Sleep Clinic and Sleep Studies are performed at Opelousas General Hospital's Sleep Disorders Center. Please park in the Sleep Center Parking Lot located at 808 N. Natchez Blvd. PLEASE be prompt.

**If you have any questions or need to reschedule your clinic visit or test, please call 943-7146 between 8:00 a.m. and 4:30 p.m., Monday through Thursday. After hours you may leave a message and / or call 407-4434 to speak with a night clinician.**

## **Welcome To Opelousas General Health System**

### **Sleep Disorders Center!**

We appreciate the confidence and trust you have placed in us and look forward to meeting you personally and professionally.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

- We are truly caring about our patients and want you to feel very comfortable with our entire staff.
- We recognize that each patient is an individual and has individual needs. Our goal is to promote excellence in the diagnosis and treatment of sleep disorders, such as sleep apnea and insomnia.
- We work with only one patient at a time; that time is reserved for you and you alone.
- We strive to be thorough in everything we do, and always attempt to achieve and uphold the standards of care set by the Academy of Sleep Medicine while providing comprehensive, quality centered, cost effective patient care in a compassionate and friendly manner.
- 

As a courtesy to you and to avoid any financial surprises, we are informing you that as a patient here, there will be 2 fees incurred – one will be the physician fee and the second will be a hospital facility fee. These 2 fees are usual for outpatient hospital services. Acadiana Medical Clinic will be billing for Dr Bordelon and Dr Nix's services, and OGHS will be billing for the facility fee.

If you have any questions or concerns regarding billing, please contact us at 337-943-7146.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Family Member/Guardian Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you, and once again, WELCOME!**



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MEMBER CENTER

Joseph Y. Bordelon, Jr., MD, D, ABSM

Louis Nix, MD, D, ABIM

NAME: \_\_\_\_\_ LOCATION: Sleep Disorders Center

I hereby give my consent to be photographed/videoed  \_\_\_\_\_

I hereby give my consent for \_\_\_\_\_ to be photographed / videoed

for the following purposes:

- 1. Educational use
- 2. Publication in scientific journals
- 3. Use in the newspaper

4 Other: Patient Chart / Sleep Disorders Center

My name or the name of my child may (may not) be used in connection therewith.

Signed: \_\_\_\_\_

If patient is a minor or unable to sign, person giving consent:

How related: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Patient No Show Policy and Timely Arrival to Appointments:**

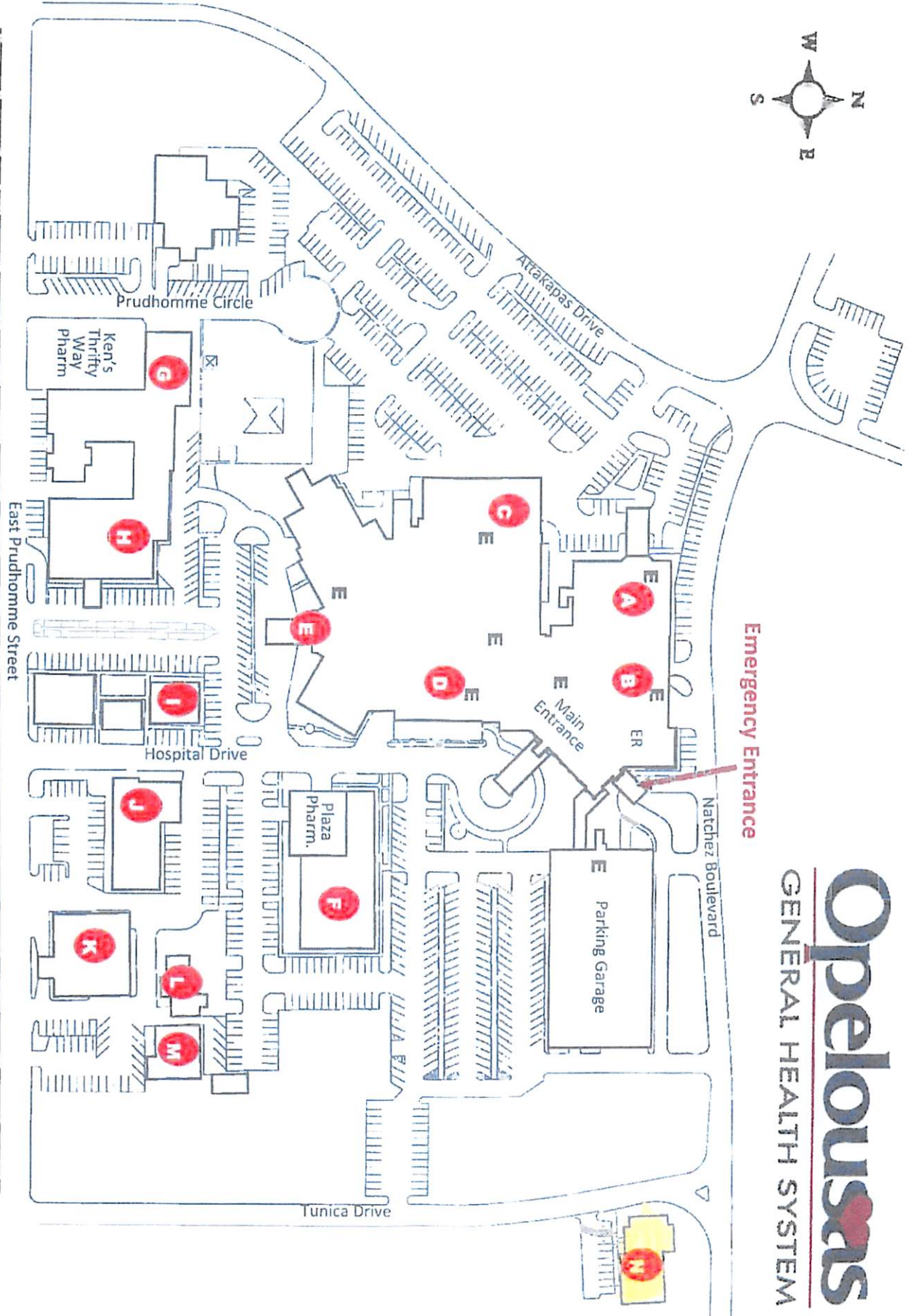
If you are more than **15 minutes** late for your appointment, we will have to reschedule your appointment for a later date. If you are unable to keep your appointment, you are required to cancel your appointment with the appropriate prior notice (24 hours is appreciated). Failure of you to cancel your appointment without a 24-hour notice is considered a “No Show” and you will be charged a **\$25.00** fee for purposes of this policy. If **two** or more appointments are missed, then you may be dismissed from our practice. We make every effort to see you in a timely manner and we ask that you respect our time and others’ time by arriving in a timely manner.

By signing below, I hereby acknowledge that I understand the above Patient No Show Policy and Timely Arrival to Appointments with the OGHS Sleep Disorders Center.

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Patient Name

Date



# Opelousas

GENERAL HEALTH SYSTEM

539 East Prudhomme Street • Opelousas, LA 70570 • (337) 948-3011 • [www.opelousasgeneral.com](http://www.opelousasgeneral.com)

OPELOUSAS GENERAL HOSPITAL  
SLEEP DISORDERS CENTER

**The Epworth Sleepiness Scale**

DATE: \_\_\_\_\_

YOUR AGE (years): \_\_\_\_\_

NAME: \_\_\_\_\_

YOUR SEX (male=M; female=F): \_\_\_\_\_

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

**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 to someone

\_\_\_\_\_

Sitting quietly after a lunch without alcohol

\_\_\_\_\_

In a car, while stopped for a few minutes in traffic

\_\_\_\_\_

**Thank you for your cooperation**

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1-6 Congratulations, you are getting enough sleep!

7-8 Your score is average.

9 and up Seek the advice of a sleep specialist without delay.



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### Sleep Disorders Center Questionnaire

Patient Name: \_\_\_\_\_  
Last First Middle

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_  
Month / Day / Year

This is a questionnaire regarding your sleeping habits that will help us understand your sleep problems. Please answer the questions to the best of your ability and if possible, have someone familiar with your sleeping habits help you.

1. Have you had a sleeping problem in the past? ( ) yes ( ) no
2. Have you ever had a sleep study done? ( ) yes ( ) no  
Where was the study done? \_\_\_\_\_  
Has CPAP / BIPAP ever been recommended? ( ) yes ( ) no  
Are you currently using CPAP / BIPAP? ( ) yes ( ) no  
What are the CPAP / BIPAP settings? \_\_\_\_\_
3. How do you describe your sleep problem? Check all that apply to you.  
( ) Difficulty falling asleep.  
What is the average number of minutes it takes for you to fall asleep? \_\_\_\_\_ minutes  
( ) Wake up during the night  
Why do you awaken during the night? \_\_\_\_\_  
What do you do when you awaken during the night? \_\_\_\_\_  
What is the average number of times per night you wake up? \_\_\_\_\_  
( ) Wake up early in the morning.  
( ) Excessive daytime sleepiness.  
( ) Difficulty awakening.
4. How many hours of sleep do you usually get on average per night? \_\_\_\_\_
5. What time do you usually go to bed on weekdays? \_\_\_\_\_ a.m./p.m. weekends? \_\_\_\_\_ a.m./p.m.
6. What time do you usually awaken on weekdays? \_\_\_\_\_ a.m./p.m. weekends? \_\_\_\_\_ a.m./p.m.





Name:

**OPELOUSAS GENERAL HOSPITAL  
SLEEP DISORDERS CENTER**

PLEASE CHECK ONE OF THE FOLLOWING FOR EACH QUESTION:

	Never	Rarely	Sometimes	Frequently	Always
Awaken from sleep short of breath					
Awaken from sleep in a "panic"					
Awaken at night with heartburn, belching, "stomach burning", or cough					
Snoring					
Snoring loudly enough to cause others to complain					
Suddenly wake up gasping for air during the night					
Have breathing problems during the night (observed by others)					
Sweat excessively at night					
Aware of your heart pounding or beating irregularly during the night					
Excessively fatigued in the daytime					
Fall asleep while reading					
Fall asleep while watching TV					
Fall asleep at gatherings					
Fall asleep during meals					
Fall asleep while at work / school					
Fall asleep while driving					
Fall asleep when laughing or crying					
Feel weak when you laugh, get angry, are surprised					
Feel unable to move (paralyzed) when waking or falling asleep (You are awake but cannot move)					
Have anxiety (worry about things)					
Experience vivid / very real dreamlike scenes upon awakening or falling asleep					
Worry in bed					

Name: \_\_\_\_\_

**OPELOUSAS GENERAL HOSPITAL  
SLEEP DISORDERS CENTER**

PLEASE CHECK ONE OF THE FOLLOWING FOR EACH QUESTION:	Never	Rarely	Sometimes	Frequently	Always
Have nightmares					
Remember your dreams					
Have thoughts racing through your mind					
Feel sad or depressed					
Have muscular tension (tight, sore muscles)					
Notice parts of your body jerk, especially in the evening					
Kick or twitch during the night, especially in the legs					
Experience crawling and aching feelings in your legs, especially in the evening					
Experience any type of leg pain during the night					
Have morning jaw pain					
Grind teeth during sleep or during the daytime					
Bothered by pain during the day					
Awaken by pain at night					
Wake up feeling stiff					
Wake up with morning headaches					
Wake up with sore or achy muscles					
Wake up with pain in neck, back or joints					
Confused in the morning					
Have been told that you stop breathing during your sleep					
Restless sleeper					
Talk in your sleep					
Sleep walk at night					
Feel afraid of going to sleep					

**SIGNATURE** \_\_\_\_\_

**DATE/TIME** \_\_\_\_\_

