Our Physicians:

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Contra Costa Sleep Center
AASM accredited diagnostic sleep center

TEL: (925) 935-7667 FAX: (925) 945-7667
Website: www.ccsleepcenter.com
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Our Locations:

(main location)
1455 Montego Ste 102
Walnut Creek, CA 94598
(satellite location)
141 Sand Creek Rd, Ste B
Brentwood, CA 94513

Now that you've completed your Home Sleep Study Testing, please take a few minutes to fill out this post study questionnaire.

This is not a test, so just fill out the answers the best that you can. Don't forget to write your name where indicated.

Thank you.

IF YOU WOULD LIKE TO RECEIVE A COPY OF YOUR SLEEP STUDY TEST RESULTS IN THE MAIL, MAKE SURE YOU FILL OUT A SELF ADDRESSED ENVELOPE AND HAND IT TO ONE OF OUR STAFF MEMBERS.

CONTRA COSTA SLEEP CENTER

Patient Satisfaction Survey

Name:_____ Date of Study:_____Technician:_____

PLEASE TAKE A FEW MINUTES TO COMPLETE THIS QUESTIONNAIRE SO WE CAN SEE WHAT KIND OF JOB WE ARE DOING.

OFFICE STAFF

	Poor (1) to Excellent (5)				
1. Was your call handled in a courteous, helpful manner?	1	2	3	4	5
2. Did you receive a call to remind you of your appointment?	1	2	3	4	5
3. Did you receive your questionnaires in the mail/fax/email/website	1	2	3	4	5

TECHNICAL STAFF

1. How well did the Technician explain the testing procedure and use of equipment?	1	2	3	4	5
2. How courteous was the Technician?	1	2	3	4	5
3. How professional was the Technician?	1	2	3	4	5
4. Was the Technician on time?	1	2	3	4	5

Thank you for choosing our service. We are dedicated to providing excellent service. Your comments allow us to ensure that all our patients receive the highest quality care possible. Please list any additional comments/suggestions below.

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CONTRA COSTA SLEEP CENTER

POST-PAP QUESTIONNAIRE

Patient Name:_____Date:_____

If you used CPAP/BIPAP at home, please answer the following questions:

1. When using the therapy, how did it compare with the length of time it usually takes you (without the therapy) to fall asleep? (Circle One)

much longer than usual | longer than usual | same as usual | shorter than usual | much shorter than usual

2. How long do you feel you slept?_____hr_____min.

3. How does this compare with the length of time you usually sleep? (Circle One)

much longer than usual | longer than usual | same as usual | shorter than usual | much shorter than usual

4. How did you feel when you woke in the morning? (Circle One)

very tired & sleepy | awake but not alert | rested | alert & wide awake

5. Do you have any physical complaints? Yes_____No_____ If so, describe:_____

_____

_____

6. Was the CPAP/BIPAP:

a. Helpful_____ Somewhat Helpful_____ Not Helpful_____

b. Comfortable_____ Somewhat Comfortable_____ Uncomfortable_____

c. Great_____ Okay_____ Unacceptable_____

d. Properly Fit_____ Adjustment was needed_____ Poorly Fit_____

7. CPAP/BIPAP will be something that I will use: Yes_____ No_____

Comments:_____

_____

_____

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