Welcome to Pulmonary and Sleep Associates of South Jersey, LLC

Cherry Hill Office: 107 Berlin Road, Cherry Hill, NJ 08034 Phone: (856) 429-1800 Fax: (856) 429-1081

Marlton Office: 750 Route 73 South, Suite 401, Marlton, NJ 08053 Phone: (856) 375-1288 Fax: (856) 375-2325

Willingboro Office: 1113 Hospital Drive, Suite 305, Willingboro, NJ 08046 Phone: (856) 375-1288 Fax: (856) 375-2325

Attached please find your new patient forms. Fill them out completely prior to arriving at our office for your appointment. Arrive 30 minutes prior to your scheduled appointment time.

Please bring the following items with you to your appointment:

1. Completed Patient Information Sheets. You may attach a list of your medications.
2. Completed Sleep Survey for Sleep Evaluation patients. If you already had a sleep study, please bring a copy of the study with you or have it faxed to our office prior to your appointment. Fax numbers for each office are listed above. If you are on CPAP or BiPAP, please bring the chip from the machine with you. Some of our physicians may ask you to bring your machine.
3. Patients for Pulmonary Consult, bring your Chest x-ray and/or CAT scan Films or CD. Do Not use inhalers/nebulizer medications (short acting meds) up to 4 hours prior to your first appointment. Do Not use long acting meds (Spiriva, Advair, etc) up to 12 hours prior to your first appointment.
4. Health Insurance Card
5. Co-Pay (if applies to your insurance)
6. A form of ID: Driver's License, passport or military ID.
7. Prescription Plan Cards (if applicable)
8. Referral, if required by your insurance co., transmitted electronically. Our NPI # is 1093734022.

*We measure your oxygen saturation via a pulse oximeter which sits on your finger. In preparation, please remove dark nail polish and or acrylic finger nail from one finger only to insure accurate results

Attention Patients

The doctors and staff greatly appreciate your courtesy in keeping all appointments promptly.

NO SHOW APPOINTMENTS: Follow up patients will be charged $25.00 for each no show appointment. If you are a new patient and No Show, you may not be able to be rescheduled.

APPOINTMENT CANCELLATION: 24 hour Notice of cancellation is required.

REFERRAL: If a referral is required by your insurance, you must obtain a referral from your primary care doctor prior to your scheduled appointment. Otherwise, your appointment will be rescheduled. We Do Not call your doctor for your referral.

COPAY: All copays are due at the time of service. We accept cash, check and credit card. A $15.00 service fee will be added to your account if your copay is not paid and must be billed.

Pulmonary and Sleep Associates of South Jersey
750 Route 73 South, Suite 401
Marlton, NJ 08053
Phone: 856-375-1288 Fax: 856-375-2325

Directions to Marlton Office

Directions from 295:

Take 295 to Exit #34A, merge onto NJ-70 E/Marlton Pike E towards Marlton. (About 2 miles) make slight right onto **Old Marlton Pike**. Take the ramp onto NJ 73. Pass the Promenade (on the left) and pass the light (Evesham Road). At the next traffic light make a left onto **Ardsley Drive** (there is no jug handle). Make a first right into Willow Ridge Office Park. Office is located in building #4 Suite 401.

Take 295 to Exit #36A, Route 73 South .Take the ramp onto NJ 73. Pass the Promenade (on the left) and pass the light (Evesham Road). At the next traffic light make a left onto **Ardsley Drive** (there is no jug handle). Make a first right into Willow Ridge Office Park. Office is located in building #4 Suite 401.

Directions from Route 73:

If headed North on Route 73: Right on **Ardsley Drive** (Target will be on your left)
Turn right into first driveway-**Willow Ridge Office Park.**
Office is located in building #4 Suite 401.

If headed South on Route 73: Left on **Ardsley Drive** (Target will be on your right)
Turn right into first driveway-**Willow Ridge Office Park.**
Office is located in building #4 Suite 401

Pulmonary and Sleep Associates of South Jersey, LLC

Pulmonary Medicine Critical Care Medicine Sleep Medicine

Patient Information

Name:	Referred by: ____self ____ physician ____ seen in hospital ____ family/friend ____ current patient
Address: City:_____ St_____ Zip_____	Referring Physician:
Email:	Primary Physician:
Home Phone #( )	Pharmacy Name
Cell Phone #( )	Pharmacy Address:
Work Phone #( )	Marital Status: _____ Single _____Married _____Divorced _____Separated ____Widowed
Date of Birth:	Ethnicity: Race:
Social Security #:	Occupation:
Emergency Contact: Name: Phone #	Sex: _____Male _____Female

Primary Insurance:	Secondary Insurance:
Identification #:	Identification #:
Policyholder's name if not patient (i.e. spouse)	Policyholder's name if not patient (i.e. spouse)
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:
Relationship to Patient:	Relationship to Patient:

Assignment and release: I hereby authorize my insurance benefits to be paid directly to Pulmonary & Sleep Associates of SJ. I understand that I am responsible for charges as designated by my insurance company/companies such as deductibles, co-pays, coinsurance, etc. I am also responsible for any and all charges not covered by my insurance. I authorize Pulmonary & Sleep Associates of SJ to release any information to my insurance company/companies when requested.

Signature_____ DATE:_____

MEDICARE-PRIMARY

_____

Name of Beneficiary

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment for medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1228B of the Social Security Act and 31 U.S.C. 3801-3812 provider penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

SIGNATURE_____ DATE:_____

The physician is not required to submit a copy of the patient signature and is not required to obtain prior approval from the carrier.

SECONDARY TO MEDICARE (MEDIGAP)

I authorize any holder of medical or other information about me to release to:
(Insurance Company Name)_____ any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits with to myself or to the party who accepts assignment.

SIGNATURE_____ DATE:_____

_____

Pulmonary and Sleep Associates of South Jersey, LLC

NAME: _____ DATE: _____

DATE OF BIRTH: _____

REASON FOR VISIT: _____

ANY RECENT HOSPITALIZATIONS - WHERE: _____ REASON: _____

PLEASE COMPLETE ALL SECTIONS THOROUGHLY.

PAST PULMONARY HISTORY AND DIAGNOSIS: (Please circle all that apply)

Abnormal CXR/CT	Hemoptysis	Pneumothorax
Asbestosis	Lung Cancer	Pulmonary Embolism
Asthma	Lung Nodule	Pulmonary Fibrosis
Bronchitis	Pleural Effusion	Pulmonary Hypertension
Bronchiectasis	Pleurisy	Sarcoidosis
COPD/Emphysema	Pneumonia	Tuberculosis
Cough		
Empyema		

PAST SLEEP HISTORY AND DIAGNOSIS: (Please circle/list all that apply)

Obstructive Sleep Apnea	
Insomnia	
Restless Legs Syndrome	
Narcolepsy	

PAST MEDICAL HISTORY AND DIAGNOSES: (Please circle any condition you have received treatment for)

Acid Reflux	Hepatitis
Atrial Fibrillation	Hypertension
Breast Cancer	Kidney Disease
Congestive Heart Failure	Prostate Cancer
Coronary Artery Disease	Seizures
Depression	OTHER
Diabetes	
Headaches/Migraines	

PAST SURGICAL HISTORY: (Please circle/list all procedures/surgeries and the year you had them)

Appendectomy	Cholecystectomy	Knee Replacement
Bronchoscopy	Gastric Bypass	Lung Biopsy
Cardiac Bypass Surgery	Hernia	Lung Resection
Cardiac Catheterization	Hip Replacement	Tonsillectomy
Cardiac Valve Replacement	Hysterectomy	
Cardioversion		

NAME: DATE OF BIRTH:

IMMUNIZATIONS: (Please check if you have had these immunizations, when & where)

Influenza Vaccine					Pneumonia Vaccine			
Yes	Date Received	Where	No		Yes	Date Received	Where	No

ALLERGIES:

Any food or environmental allergies_____

MEDICATION ALLERGIES:

Medication Name	Type of Reaction

HOME EQUIPMENT: (Please check if any of the following are being used)

Oxygen	**Since:**	**LPM**	
Cpap/BiPap	**Since:**	**Settings if known:**	
Nebulizer	**Since:**	**Used with albuterol, ipratropium-albuterol, xopenex, pulmicort,**	
Name of equipment Supplier(Company)		**Brovana, perforomist**	

MEDICATIONS: (please list all prescription and OTC medications that you currently take including vitamins and supplements)

Medication Name	Strength	Times per day		Medication Name	Strength	Times per day

FAMILY MEDICAL HISTORY: (please list all chronic illnesses and conditions in your family)

Disease (lung disease, heart disease, cancer, etc.)	Which Family Member (Mother, Father, siblings)

NAME: DATE OF BIRTH:

SOCIAL HISTORY/HOME ENVIRONMENT:

Occupation:		
Marital Status:		
Any hazardous exposures (mold, asbestos, etc):		
Where were you born:		
Any Recent Travel:	Where	When
Any Pets:	Kind:	
Smoking: Current smoker:	Duration in years:	Packs per day
Ex smoker: Year quit:	Years smoked:	Packs per day
Never smoked:	2nd hand smoke exposure:	
Cigar Smoker:	Vape:	
Alcohol Use: type	how often	Any history of abuse

SYMPTOMS: (Please circle any symptoms you are experiencing today)

Fever	Cough	Trouble Falling Asleep
Chills	Mucous/Phlegm	Trouble Staying Asleep
Night Sweats	Hemoptysis	Non restorative sleep
Fatigue	Acid Reflux	Grinding Teeth
Headaches	Muscular Weakness	Hallucinations as you fall asleep
Lightheadedness	Muscle Pains	Sleep Paralysis
Nasal Congestion	Joint Pains	Sudden loss of muscle tone
Chest Pain	Swollen Joints	Excessive Daytime Sleepiness
Chest Tightness	Anxiety	Snoring
Trouble breathing lying down	Depression	Witnessed Apneas
Swollen Legs/Feet	Insomnia	Seasonal Allergies
Shortness of breath at rest	Sleepwalking	
Wheezing	Sleeptalking	

You are welcome to visit our website: www.psasj.com
We encourage our patients to sign up and use our Patient Portal (available on our website)
Thank you for allowing Pulmonary and Sleep Associates of South Jersey to be involved with your care.
Please bring this completed form with you to your scheduled visit.

PULMONARY AND SLEEP ASSOCIATES OF SOUTH JERSEY, LLC (PSA)

PATIENT CONSENT FORMS

The Federal Government has established a "Privacy Rule" to insure personal health information (PHI) is protected. PHI means health information, including demographic information collected from me and created or received by my physician, other health care provider, health plan, employer or billing companies. PHI is kept secure in this medical practice. It is provided only when appropriate and necessary to those who need it for treatment, payment or health care operations.

PSA is required to obtain your consent to provide treatment. **YOU MAY REFUSE** to consent to the use of disclosure of your PHI, but this must be in writing. **Under the law, we have the right to refuse to treat you should you choose not to sign this consent.**

I consent to the use or disclosure of my PHI by PSA for the purposes of treatment, payment of healthcare operations. I understand that diagnosis or treatment of me by PSA may be conditioned upon my consent as evidenced by my signature below.

I may revoke this consent, in writing, at any time, except to the extent that PSA has taken action in reliance on this consent.

I have the right to review the Notice of Privacy Practices for PSA before signing this consent Form. **(IT IS ON DISPLAY IN THE WAITING ROOM FOR YOU TO READ).**

I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. PSA is not required to agree to the restrictions, however, if PSA agrees, the restriction is binding.

NAME OF PATIENT:_____

SIGNATURE OF PATIENT:_____

DATE:_____

Pulmonary and Sleep Associates of South Jersey, LLC

( ) Ammar Alimam, M.D.
( ) Donald Auerbach, M.D.
( ) Steven Baumgarten, M.D.
( ) John Bermingham, D.O.
( ) Aaron Crookshank, M.D.
( ) Michael Driscoll, D.O.
( ) Thomas Grookett, M.D.
( ) Ira Horowitz, M.D.
( ) William Morowitz, M.D.
( ) Thomas Nugent, M.D.
( ) Alan Pope, M.D.
( ) Nicholas, Roy, D.O.
( ) Antonio Velasco, D.O.

MEDICAL RECORDS RELEASE FORM

_____ _____
Patient Name Date of Birth

I hereby authorize the below listed entity to release medical information to Pulmonary and Sleep Associates of South Jersey.

Name:_____ Telephone #:_____

Address:_____ Fax #:_____

Medical information Requested:

_____ All Records

_____ Specific Records from _____to_____

_____ Immunizations & Physical Examinations

_____ Radiology Films (X-ray, Ultrasound, CT., MRI, etc)

Please send to the physician checked above and to the address circled below:

Cherry Hill Office
107 Berlin Road
Cherry Hill, N.J. 08034-3526
Phone: 856-429-1800
Fax: 856-429-1081

for Marlton and Willingboro Offices
750 Rt. #73 South, Suite 401
Marlton, N.J. 08053-4145
Phone: 856-375-1288
Fax: 856-375-2325

_____ _____
Signature of Patient or Legal Guardian Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable include; diagnosis, prognosis and treatment for physical and/or mental illness, including treatment of alcohol and substance abuse auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility which is to make the disclosure of information has already done so in reliance on the consent.

Pulmonary & Sleep Associates of South Jersey, LLC

Consent to Contact

You agree, in order for our practice to service you and to collect payments owed, Pulmonary & Sleep Associates of SJ and/or our agents may contact you by telephone at any number associated with your account including wireless telephone numbers, which could result in charges to you. We may also contact you by sending messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of automatic dialing devices, as applicable. PLEASE CIRCLE ALL THAT APPLY

	HOME PH		CELL PH		WORK PH		EMAIL	
Contact to confirm appointment	Yes	No	Yes	No	Yes	No	Yes	No
Leave appointment confirmation message	Yes	No	Yes	No	Yes	No	Yes	No
Contact to give medical information	Yes	No	Yes	No	Yes	No	Yes	No
Leave medical information message	Yes	No	Yes	No	Yes	No	Yes	No
Contact regarding payments owed	Yes	No	Yes	No	Yes	No	Yes	No
Leave message regarding payments owed	Yes	No	Yes	No	Yes	No	Yes	No

Automated Messaging System

"By supplying my home phone number, mobile number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me."

_____ *Date:* _____

Patient Signature

Pulmonary and Sleep Associates of South Jersey, LLC

E-Prescribing PBM Consent Form

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

> **Formulary and benefit transactions** - - Gives the prescriber Information about which drugs are covered by the drug benefit plan.
>
> **Medication history transactions** - - Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that *Pulmonary and Sleep Associates of South Jersey* can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (printed)_____Date of Birth ____/____/____

Signature of patient (or representative)_____

Date____/_____/_____ Relationship if other than patient_____

ONLY TO BE FILLED OUT IF YOU ARE COMING FOR A SLEEP DISORDER

Patient Name: _____ **Date:** _____

Please consult your bed partner when answering the following questions. Answer the questions as if you are describing your typical night or sleep pattern. In answering questions about frequency, you will need to check one of the following choices: *nightly, weekly, rarely, never.*

1. Are you allergic to any drugs? _____
2. Describe your sleep problem:
   _____
   _____
   _____
3. When did your sleep problem begin?
   _____ (mo/yr)
4. Have you ever had a sleep study performed?
   ☐ Yes ☐ No
5. My bed or sleeping surface is:
   ☐Standard Mattress ☐Waterbed ☐Futon
   ☐Other: _____
6. Sleep Habits:
   My ideal amount of sleep is _____ hours.

	During the week	During the weekend
I go to bed at	(time)	(time)
I get up at	(time)	(time)
I sleep	(hours)	(hours)

It usually takes me _____ minutes to fall asleep.

I usually wake up _____times a night.
Please explain what wakes you up:
_____
_____
_____

If I wake up at night, it usually takes _____ minutes to fall back asleep.
I cannot get back to sleep once I wake up
☐ Yes ☐ No

I can sleep 2 hours or more at a time:

Nightly , Weekly, Rarely, Never

7. My occupation is: _____
   My job requires shift work ☐ Yes ☐ No
   My work hours are: _____
8. I snore:
   Nightly Weekly Rarely Never
9. My snoring started at age: _____
10. I snore in all positions: ☐ Yes ☐ No
11. My snoring has been described as:

    Mild Moderate Loud

12. I stop breathing at night:
    ☐ Don't Know ☐ Yes ☐ No
13. I have problems with my nose or nasal breathing:
    ☐ Yes ☐ No
    If "YES", please explain:_____
    _____
14. I have had nasal surgery: ☐ Yes ☐ No
    If "YES", please explain:_____
    _____
15. I have had a tonsillectomy: ☐ Yes ☐ No

Nightly Weekly Rarely Never

16. I wake up gasping, short of breath, wheezing or feeling I cannot breathe: ☐ ☐ ☐ ☐
17. I wake up coughing ☐ ☐ ☐ ☐
18. I wake up with my heart beating irregularly ☐ ☐ ☐ ☐
19. I wake up with chest pain ☐ ☐ ☐ ☐
20. I wake up with heartburn or a sour acid taste in my mouth ☐ ☐ ☐ ☐
21. I wake up with a headache ☐ ☐ ☐ ☐
22. I have a bed wetting problem ☐ ☐ ☐ ☐
23. I fight sleep or fall asleep uncontrollable while sitting at meetings, watching TV, at the movies, in the car... ☐ ☐ ☐ ☐
24. I fight sleep while at work or school ☐ ☐ ☐ ☐

Patient Name_____Date of Birth_____

Nightly Weekly Rarely Never

25. I fight sleep while driving ☐ ☐ ☐ ☐
26. I have actually fallen asleep while driving a car ☐ Yes ☐ No
27. It seems that my mood, memory or thought processes have changed ☐ Yes ☐ No
28. Drowsiness is the greatest in the:
Morning Afternoon Evening

29. After a typical night's sleep, I feel:
Refreshed Fairly rested Somewhat drowsy Very tired

Nightly Weekly Rarely Never

30. I have been told I toss and turn to an extreme amount: ☐ ☐ ☐ ☐
31. I flail or kick while sleeping ☐ ☐ ☐ ☐
32. I have the feeling of "restless" legs ☐ ☐ ☐ ☐
33. I am troubled at night by uncomfortable sensations in my legs ☐ ☐ ☐ ☐
34. I wake up with muscle or joint aches or pains ☐ ☐ ☐ ☐
35. Immediately after falling asleep, I dream ☐ ☐ ☐ ☐
36. I dream during my naps ☐ ☐ ☐ ☐
37. I experience vivid dream-like scenes upon waking up or falling asleep ☐ ☐ ☐ ☐
38. I have been told that I behave strangely when not fully Awake ☐ ☐ ☐ ☐
39. I feel like I cannot move after lying down, before going to sleep, when waking up or going to sleep ☐ ☐ ☐ ☐
40. I feel sudden weakness in the knees, neck, jaw or arms when angry, sad, laughing or emotional

Daily Weekly Rarely Never

41. I have episodes of doing strange things without realizing it at the time or lose a period of time:

Daily Weekly Rarely Never

42. I take daytime naps ☐ Yes ☐ No

43. After a nap, I feel:
Refreshed Fairly rested Somewhat drowsy Very tired

Nightly Weekly Rarely Never

44. I sleepwalk: ☐ ☐ ☐ ☐
45. I talk or scream in my sleep ☐ ☐ ☐ ☐
46. I am disturbed by nightmares ☐ ☐ ☐ ☐
47. I grind my teeth when asleep ☐ ☐ ☐ ☐
48. Within the last year, depression, anxiety or stress has interfered with my sleep ☐ Yes ☐ No
49. At bedtime I have difficulty falling asleep because of worries or thoughts racing through my mind ☐ Yes ☐ No
50. My sleep problem, in addition to those previous, has resulted in:
_____
_____
51. I exercise ☐ Yes ☐ No
If "YES", what kind, what time of day, and how often?
_____
_____
52. Is there any history in your family of difficulties with sleep, excessive daytime sleepiness or snoring? ☐ Yes ☐ No
If "YES", explain:
_____
_____
53. Please list medicines tried for improving sleep or staying awake:

Drug and Dose	*Frequency*	*Started*	*Ended*

Patient Name_____Date of Birth_____

54. What methods have you tried to help you sleep at night night or stay awake during the day (besides drugs mentioned in 52)

_____

_____

55. I now smoke _____cigarettes per day.

56. I now drink _____cup(s) of caffeinated coffee, caffeinated tea or caffeinated cola per day.

57. What time of day to you drink these caffeinated beverages and how many?

_____

_____

58. I consume some alcohol _____days per week

59. What time of day do you drink these alcoholic beverages and how many?

_____

_____

60. I have a history of high blood pressure ☐ Yes ☐ No
If "YES", are you on medication for this? ☐ Yes ☐ No

61. I have a history of heart attack ☐ Yes ☐ No

62. I have a history of congestive heart failure ☐ Yes ☐ No

63. I have a history of cardiac arrhythmia ☐ Yes ☐ No
If "YES", are you on medication for this? ☐ Yes ☐ No

64. I have a history of high/low blood sugar ☐ Yes ☐ No
If "YES", are you on medication for this? ☐ Yes ☐ No

65. I have a history of lung disease ☐ Yes ☐ No
If "YES", are you on medication for this? ☐ Yes ☐ No

66. I have a history of Arthritis and Rheumatism ☐ Yes ☐ No
If "YES", are you on medication for this? ☐ Yes ☐ No

67. I have a history of hiatal hernia or reflux esophigitis ☐ Yes ☐ No
If "YES", are you on medication for this? ☐ Yes ☐ No

68. I have a history of thyroid disease ☐ Yes ☐ No
If "YES", are you on medication for this? ☐ Yes ☐ No

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (This refers to your usual 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	*0*	*1*	*2*	*3*
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive in a public place (i.e. 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 lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐