Dear prospective patient:

We thank you for choosing the Jefferson Sleep Disorders Center; we are happy to be involved in your care. Please complete the enclosed forms and initial questionnaire and bring them with you on the day of your appointment. We understand this paperwork is extensive and will take a sufficient amount of time to complete. However it is very helpful for your sleep physician and will assist with your care. If you have any questions, please call us.

Your appointment is scheduled for ______________________ at ______________________ with:

☐ Dr. Karl Doghramji  ☐ Dr. Dimitri Markov  ☐ Dr. Ritu Grewal  ☐ Dr. Zhanna Fast

You will be able to review, and receive a copy, of our Privacy Policy at the time of your visit. Please list those persons with whom we may discuss your care on the enclosed Communication of Protected Health Information form.

Also, if you have received sleep studies elsewhere, please obtain copies of the reports and bring them with you on the day of your visit. Please also bring with you copies of other laboratory study results.

WHAT TO EXPECT ON THE DAY OF YOUR INITIAL VISIT

A sleep specialist doctor will review your prior medical records, interview you, and perform a brief non-invasive physical examination.

- It is IMPERATIVE that you complete all enclosed forms PRIOR to your visit and that you BRING THEM WITH YOU to your initial visit.

- Please arrive 15 MINUTES early for your appointment. Failure to do so may cause us to reschedule your appointment. If you need to reschedule, please call 215-955-6175.

INSURANCE

At the time that you scheduled your appointment, the scheduler informed you of all referrals required by your insurance carrier. Please remember that most HMO patients must have a referral on file or a copy of the referral.

- Please bring your insurance card and driver’s license to your visit.
- Co-payments are collected at the time of your visit.
- The following is a list of provider numbers that will allow you to obtain your referral:

<table>
<thead>
<tr>
<th>Patient</th>
<th>Keystone First</th>
<th>Keystone East</th>
<th>Aetna</th>
<th>Cigna Health Springs (Bravo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Doghramji</td>
<td>1153298</td>
<td>1275707432</td>
<td>1275707432</td>
<td>1336229459 Sleep Medicine</td>
</tr>
<tr>
<td>Dr. Markov</td>
<td>1153298</td>
<td>1275707432</td>
<td>1275707432</td>
<td>1235143223 Sleep Medicine</td>
</tr>
<tr>
<td>Dr. Grewal</td>
<td>1153298</td>
<td>1275707432</td>
<td>1275707432</td>
<td>1568489334 Pulmonary</td>
</tr>
<tr>
<td>Dr. Fast</td>
<td>1153298</td>
<td>1275707432</td>
<td>1275707432</td>
<td>1265409676 Pulmonary</td>
</tr>
</tbody>
</table>
Patient Name: ____________________________ Date of Birth: ________________
(Please Print)
MRN: ________________________________

Associated Providers
Please list any physicians below who should receive information regarding your care/visit.

Primary Care Provider
Name: ____________________________ Specialty: ____________________________
Address: ____________________________
City, State: ____________________________ Zip: ____________________________
Phone: ____________________________ Fax: ____________________________

Referring Provider
Name: ____________________________ Specialty: ____________________________
Address: ____________________________
City, State: ____________________________ Zip: ____________________________
Phone: ____________________________ Fax: ____________________________

Pharmacy Information
Please complete your pharmacy information below.

Retail Pharmacy
Name: ____________________________
Address: ____________________________
City, State: ____________________________ Zip: ____________________________
Phone: ____________________________ Fax: ____________________________

Mail Order Pharmacy
Name: ____________________________
Address: ____________________________
City, State: ____________________________ Zip: ____________________________
Phone: ____________________________ Fax: ____________________________

Laboratory/Radiology Information
Are your laboratory and radiology studies capitated to a specific performing location?  □ Y  □ N
Laboratory: ____________________________ Radiology: ____________________________
I would like Jefferson University Physicians (“Jefferson”) to share my protected health information, which includes billing information, with the individuals (e.g., my spouse, parent(s), etc.) listed below.

After providing Jefferson with this completed and signed form, Jefferson agrees to communicate with the individuals listed below unless I provide Jefferson with written notice to no longer do so.

I. Patient Identification

Patient Name: _______________________________ Date of Birth: _________________

II. Authorization of Communication

I hereby grant Jefferson’s Department/Division of __________________________ permission to communicate my protected health information to the following individuals:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Patient Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Phone Number(s):</td>
</tr>
<tr>
<td>______________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Patient Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Phone Number(s):</td>
</tr>
<tr>
<td>______________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Patient Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Phone Number(s):</td>
</tr>
<tr>
<td>______________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Patient Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Phone Number(s):</td>
</tr>
<tr>
<td>______________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Patient Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Phone Number(s):</td>
</tr>
<tr>
<td>______________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Patient Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Phone Number(s):</td>
</tr>
<tr>
<td>______________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

I understand that completing this form is voluntary. I am not required to list any individuals.

Patient Signature: _______________________________ Date: _________________

Witness: _______________________________ Date: _________________

FORM 75647 (REV. 07/14)
Initial Evaluation Questionnaire

Your Name: ___________________________ DOB: ___________________________

Thank you for taking the time to write your name & DOB on each page of our questionnaire. Two patient identifiers are necessary to comply with HIPAA guidelines. It is for your safety.

What is the main problem for which you are coming to the Jefferson Sleep Disorders Center?

Please check the appropriate box regarding the indicated problem or difficulty by using the guidelines:

<table>
<thead>
<tr>
<th>Do you, OR have you ever, experienced the following? If so, please rate the following by frequency.</th>
<th>Never</th>
<th>Almost Never</th>
<th>Sometimes</th>
<th>Almost Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snore</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Wake others as a result of your snoring</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Snore louder on your back than your side</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Gaps or pauses in breathing during sleep</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Wake from sleep with choking or gasping</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Wake with a sour taste in your mouth</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Wake with dry mouth</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Wake with a headache</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Kick or leg twitch during sleep</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Have leg discomfort prior to or after falling asleep. If so, please describe:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Body rocking during sleep</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Head banging/rocking during sleep</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Fall out of bed</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other body movements during sleep. If so, please describe:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Bed wetting</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Loss of bowl control during sleep</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sleep walking</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Vivid dreams</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Night terrors</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sleep disturbed by headaches</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Paralysis during or just prior to sleep</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sudden loss of muscle control</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sudden weakness following an emotional experience</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tooth grinding</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tooth Clenching</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please continue on next page.
Do you, OR have you ever, experienced the following?
If so, please rate the following by frequency.

<table>
<thead>
<tr>
<th>Experience</th>
<th>Never</th>
<th>Almost Never</th>
<th>Sometimes</th>
<th>Almost Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep disturbed by other pains. If so, please describe:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty falling asleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty staying asleep (nocturnal awakenings)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restless and disturbed sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waking early in the AM even when unnecessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling unrefreshed after a full night’s sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take day time naps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall asleep involuntary during the day or evening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall asleep or nod off while driving</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidents as a result of falling asleep during driving</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall asleep while reading or watching TV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall asleep during conversations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall asleep in boring situations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall asleep at work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to nap even after trying</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tension that increases at bedtime</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep worse while away from home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shift-work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep in late on weekends or days off from work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel across times zones</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please write in your answer.

1. What time do you go to bed?
2. How long does it usually take you to fall asleep?
3. Number of times you awaken you a typical night?
4. Typical length of each awakening?
5. Time of your final awakening?
6. Time you finally get out of bed?
7. The length of time it takes you to feel alert after getting out of bed?
8. The time(s) when you again feel sleepy during the day?
9. The typical length of time it takes you to feel sleepy during the day?
10. How many naps you take during a typical day?
11. The typical length of each nap?
12. Do you dream during naps?

Please continue on next page.
Initial Evaluation Questionnaire

Please write in your answer.

13. Are naps refreshing?

14. Time you would go to bed given the opportunity?

15. Time you would wake up in the morning, if given the opportunity?

16. Number of naps you would take, if given the opportunity?

17. Do you sleep alone?

Sleep Related Family Medical History

Please list all family members that suffer from the following:

<table>
<thead>
<tr>
<th>Insomnia:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Daytime sleepiness:</td>
<td></td>
</tr>
<tr>
<td>Obstructive sleep apnea:</td>
<td></td>
</tr>
<tr>
<td>Narcolepsy:</td>
<td></td>
</tr>
<tr>
<td>Any other sleep disorders:</td>
<td></td>
</tr>
</tbody>
</table>

Past Medication History

Please list PAST medications including dosage, frequency, and date you began taking the medication.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th># of Times Taken Per Day</th>
<th>Date Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Food/Caffeine Intake

<table>
<thead>
<tr>
<th>Food/Drink</th>
<th>Number Per Day</th>
<th>Food/Drink</th>
<th>Number Per Day</th>
<th>Food/Drink</th>
<th>Number Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular sodas (glasses)</td>
<td></td>
<td>Regular coffee (cups)</td>
<td></td>
<td>Beer/Liquor (ounces)</td>
<td></td>
</tr>
<tr>
<td>Regular tea (cups)</td>
<td></td>
<td>Chocolate (pieces)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other alcoholic or caffeinated beverages: ___________________________

Please indicate the latest time, each day, that you have a caffeinated beverage: ___________________________
Thank you for taking the time to write your name & DOB on each page of our questionnaire. Two patient identifiers are necessary to comply with HIPAA guidelines. It is for your safety.

Please describe your occupation: ____________________________________________

Please describe your leisure activities: ______________________________________

Please indicate if you have had difficulty in any of the following areas.

<table>
<thead>
<tr>
<th>Part of Body</th>
<th>Please describe the difficulty</th>
<th>Please make your choice with a check mark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td></td>
<td>Never</td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Gland</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arms or Legs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel Movements</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please continue on next page.
Fatigue Severity Scale (FSS)

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1-7 based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

<table>
<thead>
<tr>
<th>During the past week, I have found that:</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My motivation is lower when I am fatigued</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Exercise brings on my fatigue</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>I am easily fatigued</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Fatigue interferes with my physical functioning</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Fatigue causes frequent problems for me</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>My fatigue prevents sustained physical functioning</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Fatigue interferes with carrying out certain duties and responsibilities</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Fatigue is among my three most disabling symptoms</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Fatigue interferes with my work, family, or social life</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

**FSS Score:**

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

<table>
<thead>
<tr>
<th>0 = would never doze</th>
<th>1 = slight chance of dozing</th>
<th>2 = moderate chance of dozing</th>
<th>3 = high chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passenger in a car for an hour without a break</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after lunch with no alcohol</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ESS Score:**

Patient Signature: X  Date: 

FOR PHYSICIAN OFFICE USE ONLY

I certify that I have reviewed and evaluated pages 1 through 7 with the above named patient.

Physician Signature: X  Date:  Time: 

☐ Karl Doghramji, MD  ☐ Dimitri Markov, MD  ☐ Ritu Grewal, MD  ☐ Zhanna Fast, MD
Free & Discounted Parking Available
for Jefferson Sleep Disorders Center Patients

Free Parking for:
• Any new patient of the Jefferson Sleep Disorders Center
• Any patient coming to the Jefferson Sleep Disorders Center for an overnight sleep study

Discounted Parking:
• 15% discounts are given to all patients coming for follow-up visits or CPAP Education Clinic

Please park in the Walnut Towers (Parkway Co. Parking Garage), adjacent to our building, **211 S. Ninth Street, 5th floor**. You can enter on 9th street between Locust & Walnut Streets on the right. You can enter on Walnut Street by making a left into the garage between 8th and 9th Streets. There is also an entrance on 8th street between Walnut & Locust and can be entered by making a right into the garage off of 8th street. (Map enclosed). **Drive up to the 5th level, pass the elevators, you can enter through our back door entrance, please ring the bell for admittance.**
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DELIVERING YOU TO OUTSTANDING HEALTH CARE, EVERY 15 MINUTES.

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Take a look at the easy-to-read map on the reverse and keep it handy!
Jefferson Patient & Visitor Shuttle

**Hours of Operation:**
Running every 15 minutes
Monday through Friday,
6 a.m. to 6 p.m.

*Originates at The Gallery*
*(10th Street, between Filbert and Market Streets)*

**Drop-Off and Pick-Up Locations:**
- Jefferson Station/The Gallery
  (10th Street – between Filbert and Market)
- 925 Chestnut Street
- Gibbon Building (10th Street)
- 1100 Walnut (in front of Wendy’s)
- Thomas Jefferson University
  (Locust Street, between 10th and 11th)
- Jefferson Hospital for Neuroscience (9th Street)
- 833 Chestnut Street

This map is also available on our website at Hospitals.Jefferson.edu, under "Patients and Visitors."