Sleep Health Questionnaire

☐ M ☐ F

Name | Gender | DOB

Address, City, State, Zip | Weight | Height

Cell Phone | Alt. Phone | Email

Medical Insurance Company | ID# | Group#

Section 1 - Patient Sleepiness Scale:

Step 1: Answer "Yes" or "No" for the following questions (circle Y or N). If you answer "yes" also circle the corresponding points in the column to the right.

Step 2: Total the points that you circled in the right column and record score in the space below.

Have you ever been told you stop breathing while asleep?	Y or N	8
Have you ever fallen asleep or nodded off while driving?	Y or N	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y or N	6
Do you feel excessively sleepy during the day?	Y or N	4
Do you snore or have you ever been told that you snore?	Y or N	4
Have you had weight gain and found it difficult to lose?	Y or N	2
Have you taken medication for, or been diagnosed with high blood pressure?	Y or N	2
Do you kick or jerk your legs while sleeping?	Y or N	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y or N	3
Do you wake up with headaches during the night or in the morning?	Y or N	3
Do you have trouble falling asleep?	Y or N	4
Do you have trouble staying asleep once you fall asleep?	Y or N	4
Score		

Risk Level	Low	Moderate	High	Severe
Score	0-7	8-11	12-15	16+

Section 2 - Signs & Symptoms (Check all that apply):

☐ Hypertension ☐ Snoring ☐ Diabetes

☐ Depression ☐ Grind Teeth ☐ Acid Reflux

☐ Stroke/Heart Disease ☐ Unrefreshed Sleep

☐ Family history of Snoring or Sleep Apnea

Section 3 - Sleep History (Check all that apply):

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No

Are you currently using a CPAP machine? ☐ Yes ☐ No

Do you use your CPAP less than 5 times a week? ☐ Yes ☐ No

Would you prefer an oral appliance? ☐ Yes ☐ No

Please Present Completed Form, ID & Medical Insurance Card to Front Desk to Allow for Copies

Fax: 888-999-1887 Email: orderentry@ezsleeptest.com Phone: 888-240-7735

For Office Use Only

SHQ Prescription Form

Patient Name _____ Date of Birth _____

Sleep Apnea Management & Risk Assessment Exam: (SAM Exam)

Signs & Symptoms:

- ☐ Hypertension ☐ Loud Snoring ☐ Depression ☐ GERD
- ☐ Bruxism ☐ Diabetes ☐ Narrow or V-shaped upper arch
- ☐ Soft tissue that visually impairs airway ☐ Witnessed choking or gasping for breath
- ☐ Large or scalloped tongue ☐ Neck Size (Male) ≥ 17" or Neck Size (Female) ≥ 16"

Referral Assessment: Consider sleep testing if 1 (or more) boxes below are checked

- Section 1: ☐ PSS Score ≥ 08 (Moderate - Severe)
- Section 2: ☐ 2 (or more) Signs & Symptoms indicated
- Section 3: ☐ "Yes" to 3 (or more) of Sleep History questions

Rx: Baseline home sleep study

☑ Two-night Home Sleep Study or ____-night (Indicate number of nights 1-3)

327.23 to be used to rule out OSA, unless stated differently. If other, please specify:_____

Patient Data / Vital Signs:

Height _____ Weight _____ Neck _____

BP _____ Heart Rate_____ BMI _____

Group/Practice Name _____ Doctor's Name _____

Address, City, State, Zip _____

Phone _____ Fax _____ Email _____

State License # _____ NPI # _____ Office Contact & Title _____ Account Code _____

Special Notes _____

Dr. Signature _____ Date _____

I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

(Patient to fill out and sign below if sleep test is prescribed)

Consent to Coordinated Care

Sleep disordered breathing (snoring and sleep apnea) can affect a number of systems in the body. Our practice would like to communicate with your doctors about your condition and your treatment progress in order to achieve the best outcome possible. Please provide the names and contact information for your health care team below:

Family Doctor

Name _____

Phone _____ Fax _____

Address _____

City _____ State _____ Zip _____

Other Doctor

Name _____

Phone _____ Fax _____

Address _____

City _____ State _____ Zip _____

Release of Information

By signing below, I authorize the practice listed above to release any medical information (i.e. exam findings, diagnosis, treatment programs, etc.) that is requested by:

- My primary care physician, dentist and other health care providers.
- Ez Sleep, diagnostic in-home testing provider.
- Insurance companies or other organizations or entities as may be required by said representatives for payment of claims for services provided by our practice.

_____ _____

Patient Signature Date

Fax or email Completed SHQ Forms Page 1 & 2 and include copies of ID & Medical Insurance Cards

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