## PATIENT SCREENING

Patient Name: _____

DOB: _____

***Please answer the following questions:***

| Epworth Sleepiness Scale | High Chance of dozing | Moderate Chance of dozing | Slight Chance of dozing | Never would doze off |
|---|---|---|---|---|
| 1. Do you get sleepy, or doze off, while sitting and reading? | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |
| 2. Do you get sleepy, or doze off, while watching TV? | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |
| 3. While sitting or inactive in a public place (meeting, Theater)? | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |
| 4. As a passenger in a car for an hour without a break? | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |
| 5. Lying down to rest in the afternoon? | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |
| 6. Sitting and talking tosomeone? | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |
| 7. Sitting quietly after lunch without alcohol? | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |
| 8. In a car, while stopped for a few minutes at a traffic light? | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |

**Total Score** *(sum of all numbers checked above)*
Scores ≥ 10 suggest at high risk for Obstructive Sleep Apnea

## ✓ *Check box if you answer "Yes" to the questions below:*

- ☐ Do you Snore? (louder than your breathing, at least once a month)
- ☐ Has anyone told you that you stop breathing while you sleep?
- ☐ Have you ever woken up gasping or choking?
- ☐ Do you have morning headaches? (more than once a month)
- ☐ Do you have high blood pressure?

MILLENNIUM Sleep LAB℠ FAX to: **888 834.8786**

 15 N. Gore Ave., Lower Level, Webster Groves, Missouri 63028 **Phone: (877) 933-9470**

## FOR PROVIDER

| *If patient exceeds threshold in any area, refer for HST (home sleep test).* | ***Threshold*** |
|---|---|
| Height: _____ Weight: _____ BMI: _____ | **BMI >30** |
| Neck Size (in): _____ | **>17in** |
| *From front side* **Epworth Sleepiness Score:**_____ | **ESS >= 9** |
| **Any other questions checked?** *Yes/No* | **Yes** |
| Other Symptoms or Conditions: | **Any** |

- ☐ *Hyptension*
- ☐ *Supraventricular tachycardiac or bradycardiac arrhythmias*
- ☐ *Coronary Artery Disease*
- ☐ *Diabetes*
- ☐ *Mood Disorders*
- ☐ *Low functioning thyroid*
- ☐ *Transient Ishcemic attack (TIA)*
- ☐ *Soft tissue abnormalities or neuromuscular disease involving craniofacial area or upper airway*

***If Patient meets any threshold above, please check the following conditions that apply:***

- ☐ Severe Congestive Heart Failure (NYHA class III or IV)
- ☐ Moderate Severe Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Oxygen dependent for any reason
- ☐ Cognitive impairment *(unable to follow simple instructions)*
- ☐ Neuromuscular impairment; needs assistance for activities or daily living (ADLs)
- ☐ The patient is 18 years old or younger

Fax this form with signed HST order form, insurance card front/back, and applicable insurance notes to Millenniums Sleep Lab at 888-834-8786

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