Date: _____ **Ht:**_____ **Wt:**_____**BMI:** _____

Patient Name: _____

Epworth Score from below: _____

DOB: _____

OSA Evaluation

Do you have any of the following symptoms?

- o Snoring
- o Daytime sleepiness
- o Witnessed apnea
- o Choking/gasping during sleep
- o Night sweats
- o High blood pressure
- o Morning headaches
- o Other symptoms: _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of 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 or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation	**Chance of Dozing or Sleeping**
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	
Total Epworth Score	

0-9 – average score, normal population

Epworth Sleepiness Scale reprinted with permission of the Associated Professional Sleep Societies (Johns MW; A New Method for Measuring Daytime Sleepiness: The Epworth Sleepiness Scale. SLEEP 1991; 14(6):540-545).

Interview completed by: _____

- o Patient identified as low risk.
- o Patient wishes to proceed with sleep study.
- o Patient declines sleep study at this time.

- o I have discussed the above findings with the patient and recommend a sleep study evaluation be completed with accompanying treatment as indicated.
- My APRN/PA/Clinical Nurse Specialist has discussed the above findings with the patient and I recommend a sleep study evaluation be completed with accompanying treatment as indicated.

Physicians Signature: _____