PATIENT NAME: ______________________ DOB: ______________

PHONE: ______________________ CELL: ______________________

ADDRESS: ______________________ CITY: ____________ STATE: __________ ZIP: __________

ALLERGIES: ______________ HEIGHT: ______ WEIGHT: ______ BIRTH GENDER: M ________ F ________

INSURANCE: ______________ POLICY # ______________ GROUP # ______________

Filled out by Patient

SLEEP APNEA SCREENING

Part 1 - Click Y or N

	Y	N
SNORING- Do you snore loudly (louder than talking)?		
TIRED- Do you often feel tired, fatigued or sleepy?		
OBSERVED- Has anyone observed you stop breathing?		
PRESSURE- Do you have/being treated for high BP?		
BODY- BMI more than 35kg?		
AGE- Age over 50 years old?		
NECK- Neck circumference >17" or 16" for women.		
GENDER- gender male?		

Scoring Criteria for Obstructive Sleep Apnea (OSA):

Low Risk of OSA - YES 0-2

Moderate Risk of OSA - YES 3-4

High Risk of OSA - YES 5-8

TOTAL SCORE: ________

STOP BANG QUESTIONNAIRE

Part 2 - How much do you doze off?

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
Watching T.V.				
Sitting and Reading				
Sitting inactive in a public place (i.e. theatre)				
As a passenger in a car for an hour w/out a break				
Lying down to rest in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car while stopped for a few min. in traffic				

TOTAL SCORE: ________

EPWORTH SCALE

Filled out by Physician

OFFICE USE ONLY

CHECK ONE OR BOTH

SLEEP CONSULT SLEEP STUDY

STOP BANG QUESTIONAIRE SCORE DATA

Moderate/High Risk of OSA = 3 or Higher

EPWORTH SCALE SCORE DATA

Total Score = 10 or Higher

SECTION A: REASON FOR STUDY - Please check all that apply below, including a minimum of TWO of the bolded symptoms.

- ☐ **Hypertension**
- ☐ **Ischemic Heart Disease**
- ☐ **Insomnia**
- ☐ Witnessed Apnea
- ☐ Memory Loss
- ☐ Sleep Disturbance
- ☐ Seizures
- ☐ COPD
- ☐ **History of Stroke**
- ☐ **Mood Disorders**
- ☐ Large Neck Size - 17" or greater for men / 16" or greater for women
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Morning Headache
- ☐ **Impaired Cognition**
- ☐ **Excessive Daytime Sleepiness**
- ☐ Nocturia
- ☐ Reflux
- ☐ Diabetes
- ☐ Other

	Y	N	
Is patient on oxygen?	Yes	No	LPM____

SECTION B: DIAGNOSTIC CODES

Please check at least ONE that applies.

- ☐ G47.33 Obstructive Sleep Apnea
- ☐ G47.10 Other Hypersomnia. Excessive Daytime Somnolence.

SECTION C: CPT HOME SLEEP TESTING

- ☐ Commercial 95800
- ☐ Medicare G0399
- ☐ Self-Pay

______________________ **Referring Physician Name (Printed)**

______________________ **Referring Physician Name (Signature)**

SUBMIT VIA ☐ EHR SYSTEM ☐ FAX: 352-513-2549 ☐ WEB: MHSLEEPTESTING.com