Indiana Sleep Center
701 E. COUNTY LINE ROAD, SUITE 207. GREENWOOD, IN. 46143
OFFICE317-887-6400 FAX 317-887-6500 indianasleepcenter.com

REFERRAL FOR SLEEP EVALUATION

Patient Name:_____ Phone:_____

I would like for my patient to be seen in Sleep Medicine consultation and managed by the sleep physician. □Yes □ No

If "YES" is checked disregard the following and simply sign/print name below (we will then address all the required items listed for you and your staff)

If you would like to manage your patient, please provide the following:

- **RECENT NARRATIVE OFFICE NOTE**
  The note should address the indication for sleep testing and supporting medical history.
  - **Signs and symptoms of presumptive sleep disorder such as snoring, daytime sleepiness, or observed apneas**
  - **Any known comorbid conditions such as Hypertension, Cardiac Arrhythmias, Hx. Stroke or Mood Disorders**
- **SLEEP QUESTIONNAIRE**
  Please provide one of the following:
  - **Epworth Sleepiness Scale**
  - **STOP - BANG questionnaire**
  - **Berlin questionnaire**
- **CURRENT MEDICATION LIST**
- **TYPE OF STUDY**
  - **Polysomnogram**
  - **Polysomnogram with Positive Airway Pressure**
  - **Polysomnogram with Multiple Sleep Latency Test**
  - **Other:_____.**

*Please note that our accrediting body **requires** the above information be completed **prior** to determining and performing the appropriate study. If such information is unavailable from your office, we will then make arrangements to see your patient in consultation to complete the required documentation.*

Physician Signature: _____Date:_____

Please print Physician Name: _____ Phone_____

We, at the ISC, thank you for the opportunity to participate in the care of your patients.

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PATIENT SLEEP QUESTIONNAIRE

Today's Date:_____

Section I: PATIENT INFORMATION

Patient Name:_____ DOB: _____ Height (inches):_____

Age:_____ Gender:_____ Neck Circumference (inches):_____Weight (pounds)_____

Referring Physician:_____Family Physician:_____

Section II MAJOR SLEEP RELATED COMPLAINT

☐ Excessive sleepiness ☐ Awaken with headaches ☐ Waking too early ☐ Snoring
☐ Choking sensation during sleep ☐ Difficulty falling asleep ☐ Stop breathing during sleep ☐ Sleep walking
☐ Frequent Sleep Disruptions ☐ Difficulty staying asleep ☐ Other (please explain)

1. How long have you had symptoms?_____years _____months

2. How did your symptoms begin? ☐ Suddenly ☐ Gradually ☐ Other:_____

SECTION IIIa: DAYTIME SYMPTOMS

3. Please answer the following questions with the understanding that "FATIGUE means feeling "worn out" and SLEEPINESS means "a need to sleep" or actually dozing off unintentionally.

3a. What word best describes your level of daytime FATIGUE in the last month?
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

3b. What word best describes your level of daytime SLEEPINESS in the last month?
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

4. How long has daytime sleepiness been a problem for you?
(Check NA if you have no sleepiness.) _____years ☐ NA

5. Do you feel rested when you wake up from your usual sleep period? ☐ Never ☐ Sometimes ☐ Most times

6. Do you take naps during the day? ☐ Never ☐ Sometimes ☐ Most times

7. Do you feel refreshed after brief (less than 1 hour) naps? ☐ Never ☐ Sometimes ☐ Most times

8. Do you sleep longer on the weekends or holidays than on week days? ☐ Never ☐ Sometimes ☐ Most times

9. Do you take medicine to stay awake? ☐ Never ☐ Sometimes ☐ Most times

10. During the past month, how much has sleepiness
Interfered with your normal work performance? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

11. During the past month, how much has sleepiness interfered with social activities with family, friends and other groups? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

12. Have you had accidents or near accidents because of sleepiness? (i.e., car work, home) ☐ Yes ☐ No

13. Have you **EVER** experienced **sudden** muscle weakness when you laugh? ☐ Yes ☐ No

14. When you fall asleep or just before you awaken do you experience dreams? ☐ Yes ☐ No

15. When you fall asleep or just before you awaken do you feel as if you are paralyzed? ☐ Yes ☐ No

16. Have you ever been told you have Narcolepsy? If yes, when and by whom? ☐ Yes ☐ No

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SECTION IIIb: EPWORTH SLEEPINESS SCALE

Please read the questions below and rate the chances that you would doze off or fall asleep (in contrast to just feeling tired) during different routine situations. These situations should refer to your usual way of life in recent times. Use the rating scale below.

0= Would **Never** doze or sleep
1= **Slight** likelihood of dozing or sleeping
2= **Moderate** likelihood of dozing or sleeping
3= **High** likelihood of dozing or sleeping

Situation	**Rating**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting down and talking to someone	_____
Sitting quietly after lunch	_____
In a car, while stopped for a few minutes in traffic	_____
17. Total score:	_____

SECTION IV: SLEEP HABITS

18. Workday usual bedtime: _____☐ a.m.☐ p.m. **20**: Non- workday usual bedtime: _____☐ a.m.☐ p.m.

19. Workday usual wake time:_____☐ a.m.☐ p.m. **21**: Non-workday usual wake time: _____☐ a.m.☐ p.m.

22. How many hours of sleep do you feel that you achieve on average during this period? _____Hours

23. How many hours of sleep do you feel you need to feel alert during your waking period? _____Hours

24. How long does it usually take you to fall asleep?_____

25. How often are you likely to awaken during the night? ☐ Rarely ☐ 3 times or less ☐ More than 3 times, Why?_____

26. If you awaken more than 3 times, how long does it take you to fall back asleep?_____and why?_____

27. Have you been told that you snore loudly? (If yes, how many years has the snoring been noted____) ☐ Yes ☐ No

28. Have you been told that you stop breathing during sleep? (If yes, for how many years_____) ☐ Yes ☐ No

29. Have you been told that your arms/legs jerk during sleep? ☐ Yes ☐ No

30. Are you often kept from falling asleep by an urge to move your arms, legs or torso? ☐ Yes ☐ No

31. If yes to #30 above, is the urge resolved by moving the involved body part? ☐ Yes ☐ No

SECTION V: RELATED MEDICAL INFORMATION

32. Do you or have you ever suffered from any of the following? (check all that apply.)

☐ Esophageal Reflux	☐ Stroke	☐ Claustrophobia
☐ High Blood pressure	☐ Angina/heart attack	☐ Diabetes
☐ Chronic nasal/ Sinus problems	☐ Heart Failure (CHF)	☐ Thyroid disease
☐ Chronic lung disease (COPD Emphysema)	☐ Irregular Heartbeat	☐ Treatment for depression
☐ Asthma	☐ Pacemaker/Defibrillator	☐ Restless leg syndrome

☐ Other (please explain):_____

33. List any major medical problems or illnesses you have had in the past that are not listed:_____

_____.

SECTION VI: MEDICATIONS

34. Over the last two weeks, have you often had little interest or pleasure in doing things? ☐ Yes ☐ No
If yes, has it been: ☐ Several days? ☐ More than half the days? ☐ Nearly every day?

35. Over the last two weeks, have you often been bothered by feeling down, depressed or hopeless? ☐ Yes ☐ No
If yes, has it been: ☐ Several days? ☐ More than half the days? ☐ Nearly every day?

36. List all medications that you are currently taking. Be sure to list prescription and non-prescription medications including sleep agents.

Medication Name	**Dosage Per day**	**Frequency**	**For How Long**	**Purpose**
_____	_____	_____	_____ **Yrs** _____ **Mos**	_____
_____	_____	_____	_____ **Yrs** _____ **Mos**	_____
_____	_____	_____	_____ **Yrs** _____ **Mos**	_____
_____	_____	_____	_____ **Yrs** _____ **Mos**	_____
_____	_____	_____	_____ **Yrs** _____ **Mos**	_____
_____	_____	_____	_____ **Yrs** _____ **Mos**	_____

37. List all Medication Allergies you may have:_____

38. Do have any Allergies or sensitivities to any tape or bandage? ☐ Yes ☐ No OR Latex ☐Yes ☐No

SECTION VII: PREVIOUS SLEEP APNEA DIAGNOSIS AND TREATMENT

39. Have you ever been diagnosed with sleep apnea? If yes, when_____ ☐ Yes ☐ No

If yes to above, are you currently being treated CPAP/Bi-Level therapy? ☐ Yes ☐ No

Do you feel any difference when using CPAP/ Bi-Level during sleep? ☐ Yes ☐ No

If currently using Positive Airway Pressure, please indicate the prescribed pressure _____cm/h20

Have you had problems with Positive Airway Pressure in the past and why?_____

40. Have you had any surgical treatment(s) for sleep apnea? ☐ Yes ☐ No

41. Have your tonsils been removed? If yes, when_____ ☐ Yes ☐ No

42. Do you use a dental appliance for sleep apnea or teeth grinding? ☐ Yes ☐ No

SECTION VIII: SOCIAL HABITS AND FAMILY HISTORY

43. Do you drink alcoholic beverages, If yes, indicate the type, quantity and frequency below ☐ Yes ☐ No

If yes, what type?_____Number of glasses/cans/ bottles:_____per ☐ Day ☐ Week ☐ Month

44. Do you drink caffeinated beverages? If yes, indicate type, quantity and frequency below. ☐ Yes ☐ No

If Yes, what type?_____ Number of glasses/cans/ bottles:_____per ☐ Day ☐ Week ☐ Month

45. Have you gained any weight over the last year? ☐ Yes ☐ No

If Yes, how much_____Pounds

46. Do other family members have similar sleep problems? ☐ Yes ☐ No

47. What is your occupation?_____

48. What are your usual working hours?_____

49. Please use the following space to elaborate on other related information about your medical or sleep complaints.

_____

_____

SECTION IX: OBSERVATIONS BY OTHERS

50. If you have had the opportunity to observe this patient's sleep please check any of the behaviors that apply and how long they have occurred.

☐ Snore or snort: _____years _____Months ☐ Stops breathing/Gasps for air: _____years _____Months

☐ Leg/arm/ body jerks: _____years _____Months ☐ Violent behavior/ Acting out dreams: _____years _____Months

☐ Grind Teeth: _____years _____Months ☐ Screaming/Walking in sleep: _____years _____Months

Use the space below for additional comments._____

_____

_____

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STOP-BANG Questionnaire

1. *S*noring; Do you *s*nore loudly (louder than talking or loud enough to be heard through closed doors)? **Yes/No**

2. *T*ired; Do you often feel *t*ired, fatigued, or sleepy during daytime? **Yes/No**

3. *O*bserved; Has anyone *o*bserved you stop breathing during your sleep? **Yes/No**

4. Blood Pressure; Do you have or are you being treated for high blood *p*ressure? **Yes/No**

5. *B*MI; *B*MI more than 35? **Yes/No**

6. *A*ge; *A*ge over 50 yr old? **Yes/No**

7. *N*eck circumference; *N*eck circumference greater than 15.75 Inches? **Yes/No**

8. *G*ender; *G*ender male? **Yes/No**

Total "YES"_____

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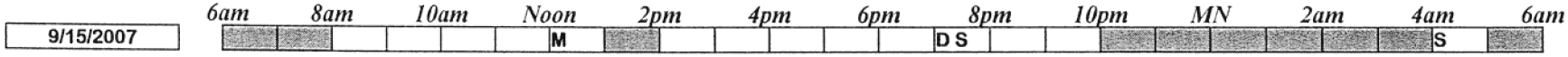
SLEEP LOGS

Name: _____

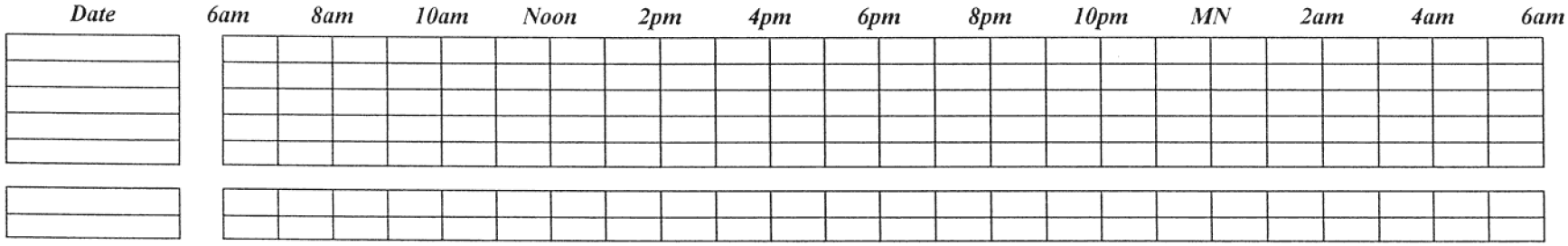
INSTRUCTIONS: **(Complete these logs as instructed using the directions provided below. Complete the logs in the morning and the evening. Do not complete the logs during the night. Write additional comments on the back Bring these logs with you for your appointment or mail them to your physician.)**

1. Leave the times you are awake BLANK.
2. SHADE or crosshatch, or color the times when you sleep
3. "M" for meals, "S" for snacks, and a "D" for drinks with alcohol.
4. Include notes below or on back

EXAMPLE:



FIRST WEEK



SECOND WEEK