AWAKEN 2 SLEEP HOME SLEEP STUDY | **Rx FORM**

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Name | ○ M ○ F Gender | DOB

Address, City, State, Zip | Weight | Height | Neck Size

Cell Phone | Alt. Phone | Email

PPO Medical Insurance Company | (Non-PPO) | ID# | Group#

Have you ever been diagnosed with a sleep disorder? ○ YES ○ NO Night time oxygen use? ○ YES ○ NO

Are you currently using a CPAP Machine? ○ YES ○ NO (if YES) Do you use it every night? ○ YES ○ NO

Answer **"YES"** or **"NO"** to the following questions: (circle Yes or No answer)

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

Score and Risk Factor (Add the points that you have answered "YES")

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

Dx: **FOR OFFICE USE ONLY**

☐ Sleep Apnea (Observed)	☐ Snoring (Habitual)	☐ Stroke	☐ Obesity
☐ OSA (Diagnosed)	☐ Gasping/Choking	☐ Heart Attack	☐ Insomnia
☐ Excessive Daytime Sleepiness	☐ Soft Tissue Abnormality (Upper Airway)	☐ Hypertension	☐ Depression

Rx:

☐ Two-night Home Sleep Study or ___-night
☐ Diagnostic ☐ Efficacy (w/ oral appliance)

Other Services:

☐ Overnight attended Polysomnogram ☐ Sleep Specialist Consultation
☐ CPAP/BIPAP Titration ☐ Other _____

NOTES:

Practice/Group Name | Doctor Name

Physical Address | Account Code

Phone | Fax | Email

State License # | NPI #

Dr. Signature | Date | Office Contact

The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.