**Easy Screener Epworth Sleepiness Scale**

Name: _____ DOB: _____

Phone Home: _____ Work: _____ Cell: _____

Address: _____

City, State, Zip: _____

**The Epworth Sleepiness Scale**

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Even if you have not done some things recently, try to work out how they would have affected you. Use the scale below to choose the most appropriate number for each situation. Write the numbers on each line and add them up on the total line.

**Scale for chance of dozing: 0=*never* 1=*slight* 2=*moderate* 3=*high***

| Situation | Chance of dozing |
|---|---|
| Sitting and reading | |
| Watching television | |
| Sitting inactive in a public place (e.g. a theater, meeting) | |
| Sitting as a passenger in a car for an hour without a break | |
| Lying down to rest in the afternoon when circumstances permit | |
| Sitting and talking to someone | |
| Sitting quietly after lunch without alcohol | |
| Sitting in a car while stopped for a few minutes in traffic | |
| **Total Score** | |

## Please Circle One

| | | |
|---|---|---|
| Do you snore loudly or does it bother your bed partner? | **YES** | **NO** |
| Are you excessively tired or sleepy during the day? | **YES** | **NO** |
| Have you been told you stop breathing during sleep? | **YES** | **NO** |
| Do you wake during the night feeling breathless or gasping? | **YES** | **NO** |
| Do you wake up feeling un-refreshed after a night's sleep? | **YES** | **NO** |
| Do you have a history of hypertension? | **YES** | **NO** |
| Male Gender or Menopausal Female? | **YES** | **NO** |
| Do you have trouble going to sleep or staying sleep? | **YES** | **NO** |

*Epworth Sleepiness Scale of 10 or greater or "Yes" to four (or more) of the circled questions is a positive screen for sleep disordered breathing; you may want to discuss this with your physician.*

Patient Signature: _____ Date: _____ Time: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

NOVANT HEALTH

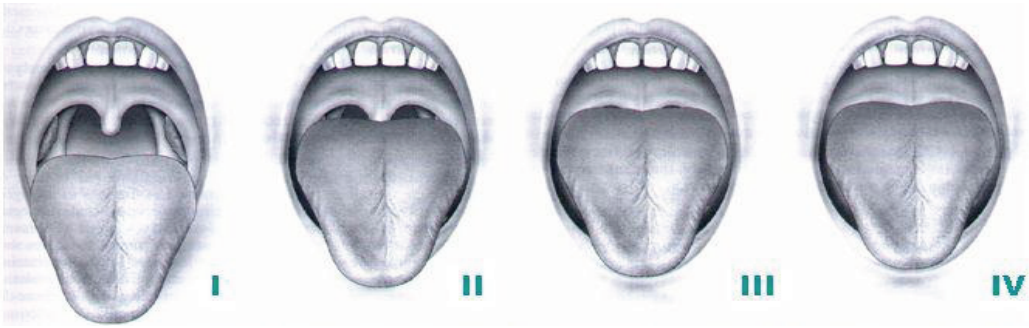
**Easy Screener Epworth Sleepiness Scale**



Name / MR # / Label

## PHYSICIAN USE ONLY

## Physical Exam: circle one below




**Class I** **Class II** **Class III** **Class IV**
*** ****

BMI>30?: ☐YES ☐NO Neck Circumference: _____ >17" Men _____ >16" Women

Heart/Lungs: ☐ Normal ☐ Abnormal

## Co-Morbidities:

_____ **HTN** _____ **Cardiac Arrhythmias** _____ **CVD**

_____ **CAD** _____ **Diabetes Mellitus** _____ **CHF**

_____ **Other** _____ **Metabolic Syndrome** _____ **Hyperlipidemia**

☐ **Referring Physician/Patient would like to arrange Consult/Comprehensive care by a sleep physician.**

- ☐ Diagnostic Polysomnogram (PSG)
  CPAP initiated per protocol if criteria for severe Sleep Related Breathing Disorder (SRBD) are met.
- ☐ Continuous Positive Airway Titration (CPAP and/or Bi-Level PAP as indicated)
- ☐ Multiple Sleep Latency Test (MSLT) *(requires a sleep consult)*
- ☐ Maintenance of Wakefulness Test (MWT) *(requires a sleep consult)*

☐ **Home Sleep Study**

Patient Name: _____ DOB: _____

Phone Home: _____ Work: _____ Cell: _____

**Physician Signature:** _____ **Dx**: _____ **Date:** _____ **Time:** _____

**Phone Number:** 1-877-99-AWAKE (29253) **Fax Number:** 1-855-805-3495

NOVANT HEALTH

**Easy Screener Epworth Sleepiness Scale**



Name / MR # / Label