

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)



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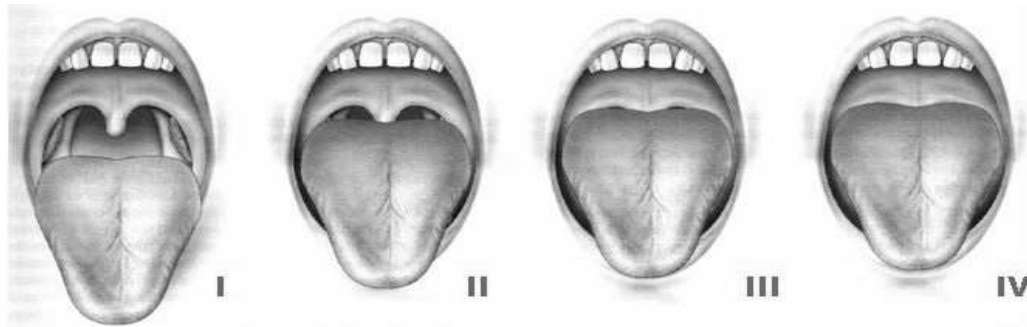


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Name / MR # / Label

**Easy Screener Epworth Sleepiness Scale
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



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