California Cardiovascular Consultants & Medical Associates

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SLEEP APNEA ASSESMENT

Your physician is requesting that you complete this Sleep Assessment Form. This form determines the need for you to have a user-friendly home sleep test, which will evaluate if you have a sleep disorder. Sleep Disorders negatively affect your well-being and especially your cardiovascular health but can be effectively treated.

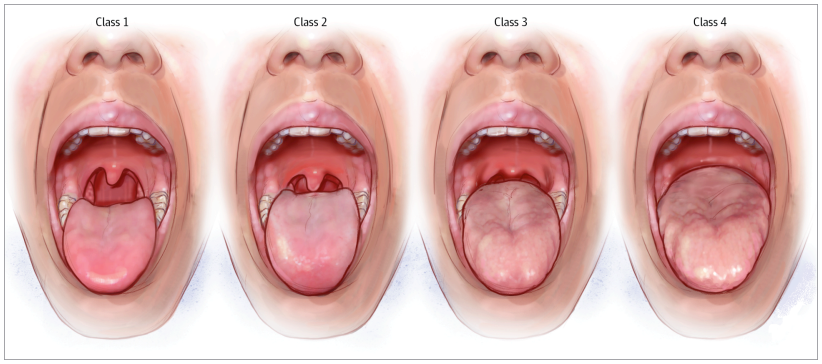
Date: _____ Physician Name: _____
Name: _____ Date of Birth: _____ Email: _____
Phone: (Home) _____ (Cell) _____ Best Call Time(s): _____

For Patients on CPAP

1. Have you ever been worked up for sleep apnea? Yes _____ No _____
2. Have you ever been given a CPAP device? Yes _____ No _____
3. If you have been given any form of CPAP, do you use it nightly? Yes _____ No _____
4. Are you comfortable with your CPAP and satisfied with its use? Yes _____ No _____

If your answer is **NO** to any of these above questions, please continue to Part 1.
If the answer is Yes to all, PLEASE STOP.

Part I **Mallampati Score**



Part II **Epworth Sleepiness Scale**

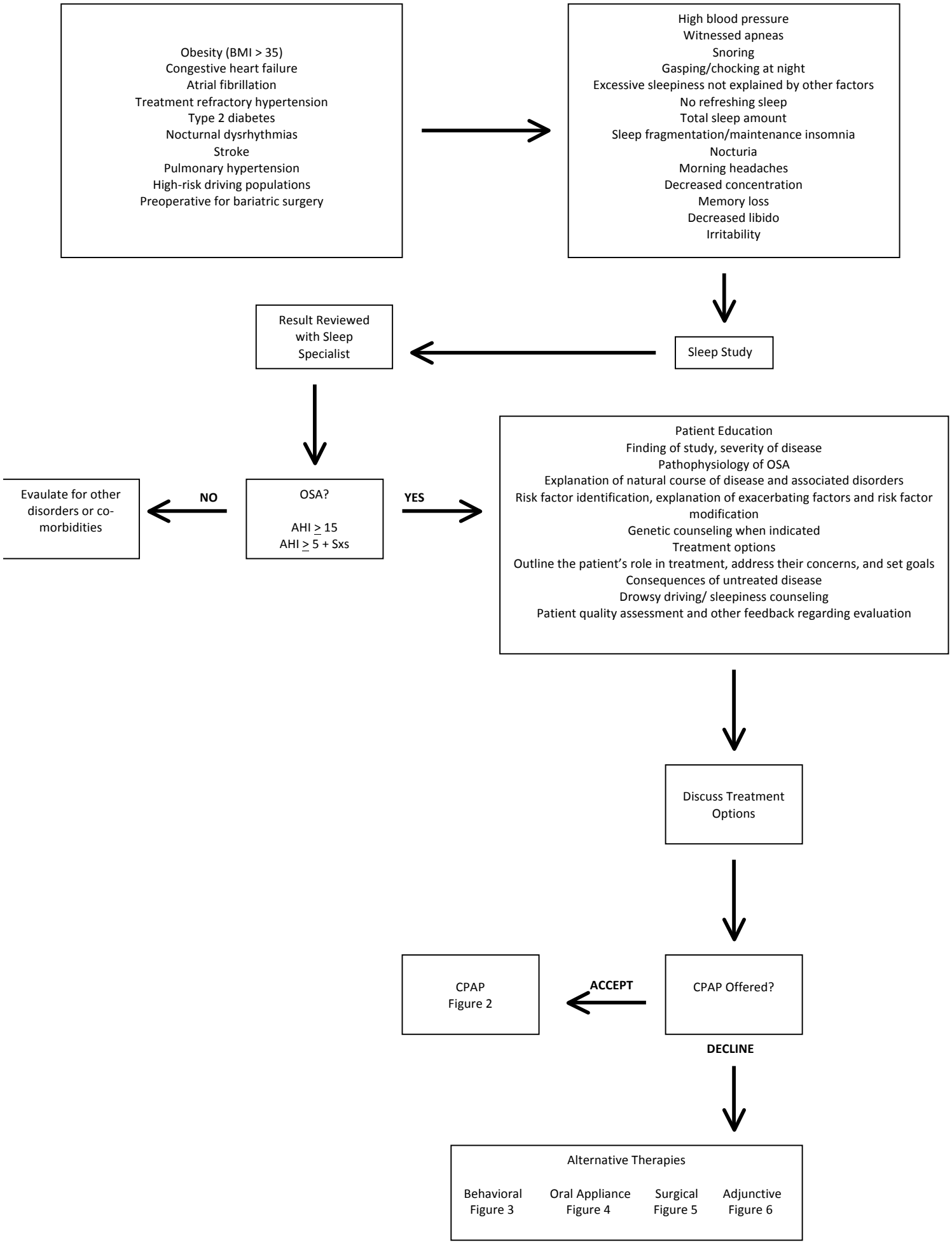
How likely are you to doze off while doing the following activities?
Please use the following scale: **0 = never, 1 = slightly, 2 = moderate, 3 = high**. Circle one of the following numbers.

1. Being a passenger in a motor vehicle for an hour or more 0 1 2 3
2. Sitting and talking to someone 0 1 2 3
3. Sitting and reading 0 1 2 3
4. Watching TV 0 1 2 3
5. Sitting inactive in a public place 0 1 2 3
6. Lying down to rest in the afternoon 0 1 2 3
7. Sitting quietly after lunch without alcohol 0 1 2 3
8. In a car, while stopping for a few minutes in traffic 0 1 2 3

Total score _____

Part III

1. Have you been told that you snore? Yes ____ No ____
2. Does your family have a history of premature death in sleep? Yes ____ No ____
3. Do you have Diabetes? Yes ____ No ____
4. Have you ever been told you have Coronary Artery Disease? Yes ____ No ____
5. Do you have High Blood Pressure? Yes ____ No ____
6. Have you ever experienced irregular heart rhythms? Yes ____ No ____
7. Do you awaken from sleep with chest pain or shortness of breath? Yes ____ No ____
8. Has anyone said that you seem to stop breathing while sleeping? Yes ____ No ____
9. Is your neck size larger than 15” (female) or 16.5” (male) Yes ____ No ____
10. Have you ever had a Stroke? Yes ____ No ____
11. Have your ever been told you have Congestive Heart Failure? Yes ____ No ____
12. Do you have or did you ever have Atrial Fibrillation? Yes ____ No ____
13. Have you been taking pain medications such as narcotics/opioids? Yes ____ No ____


Obesity (BMI > 35)
Congestive heart failure
Atrial fibrillation
Treatment refractory hypertension
Type 2 diabetes
Nocturnal dysrhythmias
Stroke
Pulmonary hypertension
High-risk driving populations
Preoperative for bariatric surgery
High blood pressure
Witnessed apneas
Snoring
Gasping/chocking at night
Excessive sleepiness not explained by other factors
No refreshing sleep
Total sleep amount
Sleep fragmentation/maintenance insomnia
Nocturia
Morning headaches
Decreased concentration
Memory loss
Decreased libido
Irritability
Sleep Study
Result Reviewed with Sleep Specialist
OSA?
AHI ≥ 15
AHI ≥ 5 + Sxs
NO
Evaulate for other disorders or co-morbidities
YES
Patient Education
Finding of study, severity of disease
Pathophysiology of OSA
Explanation of natural course of disease and associated disorders
Risk factor identification, explanation of exacerbating factors and risk factor modification
Genetic counseling when indicated
Treatment options
Outline the patient's role in treatment, address their concerns, and set goals
Consequences of untreated disease
Drowsy driving/ sleepiness counseling
Patient quality assessment and other feedback regarding evaluation
Discuss Treatment Options
CPAP Offered?
ACCEPT
CPAP
Figure 2
DECLINE
Alternative Therapies
Behavioral
Figure 3
Oral Appliance
Figure 4
Surgical
Figure 5
Adjunctive
Figure 6