


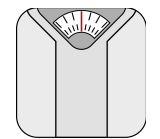

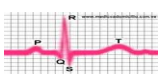






**Clinical Sleep Documentation Guide for Physicians**

	<p><b>Yes</b></p>	<p><b>SLEEP APNEA</b></p> <p><input type="checkbox"/> Observed Apnea  <input type="checkbox"/> Habitual snoring, choking, gasping, and cessation of breathing that awakens patient  <input type="checkbox"/> Diagnosed OSA with continuing symptoms  <input type="checkbox"/> Oropharyngeal crowding - small airway – tonsillar hypertrophy</p>																		
	<p><b>Yes</b></p>	<p><b>SUSPECTED SLEEP DISORDERS that include the following</b></p> <p><input type="checkbox"/> Central Sleep Apnea <span style="margin-left: 200px;"><input type="checkbox"/> Parasomnia (nightmares)</span>  <input type="checkbox"/> Periodic Leg Movement (PLM) <span style="margin-left: 150px;"><input type="checkbox"/> Narcolepsy</span></p>																		
	<p><b>Yes</b></p>	<p><b>EXCESSIVE DAYTIME SLEEPINESS (EDS)</b></p> <p><input type="checkbox"/> Sleepiness that interferes with daily activities  <input type="checkbox"/> Daytime napping (can be while riding, eating, talking, etc)</p>																		
	<p><b>Yes</b></p>	<p><b>OBESITY</b></p> <p><input type="checkbox"/> BMI &gt; 30 <span style="margin-left: 50px;"><input type="checkbox"/> Morbid Obesity BMI &gt; 33</span>  <input type="checkbox"/> Neck size greater than &gt; 17 for men, greater than &gt;16 for women</p>																		
	<p><b>Yes</b></p>	<p><b>SAFETY – Physical Problems and Memory Loss</b></p> <p><input type="checkbox"/> Unable to follow directions  <input type="checkbox"/> Physical Impairment</p>																		
	<p><b>Yes</b></p>	<p><b>CARDIAC</b> <span style="float: right;"><input type="checkbox"/> <b>Other:</b> _____</span></p> <p><input type="checkbox"/> Treatment Resistant Hypertension <span style="margin-left: 50px;"><input type="checkbox"/> Congestive Heart Failure moderate &gt; severe</span>  <input type="checkbox"/> Nocturnal Angina <span style="margin-left: 150px;"><input type="checkbox"/> Cardiac Arrhythmias</span>  <input type="checkbox"/> Myocardial Infarction <span style="margin-left: 100px;"><input type="checkbox"/> Myocardial Ischemia</span></p>																		
	<p><b>Yes</b></p>	<p><b>NEUROLOGICAL</b> <span style="float: right;"><input type="checkbox"/> <b>Other:</b> _____</span></p> <p><input type="checkbox"/> CVA (within 30 days) <span style="margin-left: 50px;"><input type="checkbox"/> Neuromuscular Disease</span>  <input type="checkbox"/> Parkinson's Disease <span style="margin-left: 50px;"><input type="checkbox"/> Nocturnal Seizures</span></p>																		
	<p><b>Yes</b></p>	<p><b>EPWORTH SCALE &gt; 10</b></p> <p><b>0 = no chance of falling asleep</b>  <b>1 = slight chance of falling asleep</b>  <b>2 = moderate chance of falling asleep</b>  <b>3 = high chance of falling asleep</b></p> <p><b>Total Score</b> _____</p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">ACTIVITY</th> <th style="text-align: left;">chance of falling asleep</th> </tr> </thead> <tbody> <tr> <td>Sitting and reading</td> <td>_____</td> </tr> <tr> <td>Watching TV</td> <td>_____</td> </tr> <tr> <td>Sitting inactive in a public place</td> <td>_____</td> </tr> <tr> <td>Passenger in car &gt; hour</td> <td>_____</td> </tr> <tr> <td>Lying down to rest afternoon</td> <td>_____</td> </tr> <tr> <td>Sitting and talking to someone</td> <td>_____</td> </tr> <tr> <td>Sitting quietly after lunch</td> <td>_____</td> </tr> <tr> <td>While driving a car</td> <td>_____</td> </tr> </tbody> </table>	ACTIVITY	chance of falling asleep	Sitting and reading	_____	Watching TV	_____	Sitting inactive in a public place	_____	Passenger in car > hour	_____	Lying down to rest afternoon	_____	Sitting and talking to someone	_____	Sitting quietly after lunch	_____	While driving a car	_____
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	<p><b>Yes</b></p>	<p><b>PULMONARY</b> <span style="float: right;"><input type="checkbox"/> <b>Other:</b> _____</span></p> <p><input type="checkbox"/> COPD  <input type="checkbox"/> Oxygen dependent</p>																		
	<p><b>Yes</b></p>	<p><b>MEDICATIONS</b> <span style="float: right;"><input type="checkbox"/> <b>Other:</b> _____</span></p> <p><input type="checkbox"/> Current use of opiates or narcotics</p>																		