SLEEPMED ARES Questionnaire ©

SleepMed

PRINT IN CAPITAL LETTERS - STAY WITHIN THE BOX All Fields Required-unless otherwise specified

Last Name | First Name | Middle Initial | Gender: Male ☐ Female ☐

Date of Birth Month | Day | Year **Weight** Pounds **Height** Feet | Inches **Neck Size** Inches

I.D. Number (optional)

Tally ARES Risk Points

Neck Size +2 Male ≥16.5 +2 Female ≥15

Score ☐

COMPLETELY FILL IN ONE SQUARE FOR EACH QUESTION - ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Heart disease	Yes ☐	No ☐	Depression	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Sleep Apnea	Yes ☐	No ☐
Lung disease	Yes ☐	No ☐	Nasal oxygen use	Yes ☐	No ☐
Insomnia	Yes ☐	No ☐	Restless legs syndrome	Yes ☐	No ☐
Narcolepsy	Yes ☐	No ☐	Morning Headaches	Yes ☐	No ☐
Sleep Medication	Yes ☐	No ☐	Pain Medication e.g. vicodin, oxycontin	Yes ☐	No ☐

Co-morbidities +1 for each Yes response

Score ☐

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of *these things recently, try to work out* how they would have affected you. Use the following scale tomark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze 1 = slight chance of dozing
2 = moderate chance of dozing 3 = high chance of dozing

	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, inactive, in a public place (theater, meeting, etc)	☐	☐	☐	☐
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	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Epworth Score Total the values from all 8 questions. If 11 or less Score = 0 If 12 or more Score = 2

Score ☐

Frequency (Check one for each question): Never **+0**, Rarely **+1** times/wk, Sometimes **+2** times/wk, Frequently **+3** times/wk, Almost Always **+4** times/wk.

On average in the past month, how often have you snored or been told that you snored?

Never +0 ☐ Rarely +1 ☐ Sometimes +2 ☐ Frequently +3 ☐ Almost always +4 ☐

Do you wake up choking or gasping?

Never +0 ☐ Rarely +1 ☐ Sometimes +2 ☐ Frequently +3 ☐ Almost always +4 ☐

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never +0 ☐ Rarely +1 ☐ Sometimes +2 ☐ Frequently +3 ☐ Almost always +4 ☐

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always ☐

Assign points for each of the first three responses

Point Total ☐

I have personally completed this questionnaire.
Signature

Date

Phone Number

Epworth Sleepiness Scale:
If points total =3 or lower (no risk)
4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)

Arizona Neurology and Sleep Center
www.azns.org

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At **Arizona Neurology and Sleep Center** we are always striving to improve our patient's health by staying current in both our techniques and diagnostic equipment. Recently we purchased a new technology that will allow you, the patient, to have your sleep studied in the comfort of your own home. Many of our patients were uncomfortable with the cost and process of outpatient sleep laboratories and we are excited to bring this new, easy to use and economical solution to our patients.

While the monitoring device is in my possession, I agree to exercise care in its use and handling, and return it within the promised time frame in working condition. I understand that delays in its return causes problems for other patients who need this service.

FINANCIAL RESPONSIBILTY

I understand that if the device is lost, stolen or damaged while in my possession, I am responsible to pay **Arizona Neurology and Sleep Center** for the replacement of this device. The charge for replacing the Home Sleep Test is **$ 995.**

I am checking this device out on _____(date) and I agree to return it on _____ _____(date) (before 11am) at the conclusion of my sleep test so that other patients may have the same opportunity to be tested as I did. If I do not return it by the date above I agree to pay a ~~$25~~ $250 per day late fee until the equipment is returned.

Patient Name _____

Patient Signature _____

Date _____

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SLEEP STUDY CONSENT FORM HOME STUDY

- My physician has explained the sleep study to me as well as the benefits and risks of having the test performed.
- I have had the opportunity to ask my physician and my sleep technologist questions, and I consent to the sleep study.
- I was shown in detail and in-person how to apply the Home Sleep Testing equipment by a Registered Polysomnographic Technologist (RPSGT) as well as given reference materials to take home with me and given the number to the night sleep technologist on duty.
- I will bring back the Home Sleep Testing Equipment (Apnea Link) the morning after my sleep study or I will be charged for the equipment which could be up to $2000.

Print Patient Name: _____

Patient Signature: _____

Date: _____ Time: _____ AM/PM

Signature of Parent/Conservator/Guardian: _____

Relationship: _____

Hospital Witness: _____