SLEEP APNEA SCREENING QUESTIONNAIRE

Patient name:	Date:

1.	Do you snore loudly? (loud enough to be heard through walls or a door)	Yes	No
2.	Do you often feel tired, fatigued, or sleepy during the day?	Yes	No
3.	Has anyone observed you stop breathing during your sleep?	Yes	No
4.	Do you have or are you being treated for high blood pressure or type II diabetes?	Yes	No
5.	Are you obese/very overweight – BMI > 35km/m2?	Yes	No
6.	Are you over 50 years old?	Yes	No
7.	NECK circumference > 17 inches for men, 16 inches for women	Yes	No
8.	Are you male or female?	Male	Female
	If female, are you post-menopausal?	Yes	No

Score: Yes to 0-2 – low risk for obstructive sleep apnea/Yes to 3-4 – moderate risk for OSA/Yes to 5 or more – high risk for OSA

ADDITIONAL QUESTIONS

a.	Have you ever been diagnosed or are you currently being treated for sleep apnea?	Yes	No
b.	Have you ever had a sleep study before?	Yes	No
c.	Do you experience leg/limb jerks during your sleep?	Yes	No
d.	Has anyone ever complained of your legs/limbs jerking while you sleep?	Yes	No

---------- Staff Use Only ----------

Age:		BMI:		Neck Circumference:	in.	ESS:	

Base on the patient's clinical history outlined in this sleep apnea questionnaire this patient is considered at moderate to high risk for Obstructive Sleep Apnea.

☐ PSG/HST (based on insurance requirements) - PSG – 95810 HST – 95806/G0399

☐ CPAP titration study – 95811

☐ Evaluate and treat - Sleep study with CPAP titration if indicated (Split night study) – 95810 or 95811 if necessary.

☐ Multiple Sleep Latency Test (MSLT) 95805 ☐ Maintenance of Wakefulness Test (MWT) 95805

Diagnosis code: ☐ G47.33 Obstructive Sleep Apnea ☐ Other: _____

Physician Signature	Time:	Date:
Physician's Printed Name		

With my signature, this becomes an order.

SUMMIT MEDICAL SLEEP CENTER

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