Lawrence General Hospital
So good. So caring. So close.

The Sleep Center at Lawrence General Hospital
1 General Street Lawrence, MA 01841
(978) 946-8297 sleepcenter@lawrencegeneral.org

Sleep Center EZ Form

Please fax completed forms with most recent office notes and other applicable documentation to 978-946-8102

The Epworth Sleepiness Scale

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation Chance of Dozing

Sitting and reading _____
Watching TV _____
Sitting inactive in a public place (e.g., a theater or a meeting) _____
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 a lunch without alcohol _____
In a car, while stopped for a few minutes in traffic _____

Total Score = _____

Analyze Your Score
Interpretation:
0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.

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Patient Name _____ DOB ___/____/_____ Preferred Language_____

Address _____ City _____ State _____

Home Phone _____ Cell _____ Work_____

Height (cm) _____ Weight (kg) _____ BMI _____ Neck Size _____ Epworth Score _____

Insurance Company _____**Policy #**_____

Masshealth referral number if applicable_____

Has patient had previous sleep study?

☐ YES ☐ NO

REQUESTED TEST

☐ **Split Night: IN-LAB-**Diagnostic study & CPAP Titration if criteria are met (95811)

☐ **PSG: IN-LAB**-Diagnostic sleep study only (Adult 95810, Pediatric <6y/o 95782)

☐ **PAP Titration**: **IN-LAB**-Full night titration for pts. with documented OSA (95811)

☐ **HSAT**: **Home Sleep Apnea Test**-Patient will bring home the testing device (G0399)

Specialized (less common):

☐ MSLT

☐ MWT

☐ Other _____

DIAGNOSIS

☐ Obstructive Sleep Apnea
☐ Unspecified Sleep Apnea
☐ Central Sleep Apnea
☐ Restless Leg Syndrome
☐ Narcolepsy
☐ Parasomnias
☐ Idiopathic Hypersomnolence
☐ REM Behavior Disorder
☐ Other: _____

SYMPTOMS

☐ Chronic Fatigue
☐ Excessive sleepiness
☐ Observed Apneas
☐ Loud Snoring
☐ Gasping/Choking
☐ Leg Restlessness/Jerks
☐ Sleep Walking/Talking
☐ Negative HST
☐ Hypertension
☐ Other: _____

Duration _____

COMORBIDITIES

☐ Moderate to Severe Pulmonary Disease (COPD, Asthma)
☐ Neuromuscular Disease
☐ Significant Cardiac Disease
☐ Obesity Hypoventilation Syndrome
☐ Obesity
☐ Patient on Opiates or SSRIs
☐ Physical Impairment that Prevents Home Sleep Testing
☐ Negative or Inconclusive HSAT with High Likelihood of OSA
☐ History of Central or Mixed Apnea (previously documented)
☐ HCO3 ≥29
☐ Moderate to Severe CHF
☐ History of Nocturnal Seizures
☐ History of Stroke
☐ Other_____

☐ **I wish to enroll my patient in the LGH comprehensive sleep management program. Ongoing PAP management (if applicable) will be handled by the LGH sleep specialist.**

I attest that the documentation submitted is accurate to the best of my knowledge. I authorize submission of this information for the purposes indicated above:

Ordering Provider Signature _____

Print Name _____

Date _____NPI#_____