SOUND SLEEP HEALTH
Tel: 425-636-2400
Fax: 425-636-2401

Thank you for choosing Sound Sleep Health! We look forward to participating in your patient's care.

Patient's Name: _____ **Date of Birth:** ____/____/____

Phone: (____) _____ **Date:** _____

REASONS	CIRCLE ALL RELEVANT CONCERNS/RISK FACTORS:
☐ Insomnia	Trouble with: Falling asleep • Staying asleep • Shallow sleep • Waking too early Shift worker • Night owl • Morning lark • Irregular sleep/wake schedule ADD/ADHD • PTSD • Anxiety • Depression • Bipolar • Substance issue Fibromyalgia • CFS • Chronic Pain • Migraine/Chronic headache Would like to ☐ change sleeping pill or ☐ get off sleeping pill Memory impairment • Cognitive difficulty Other:
☐ Somnolence/ Narcolepsy	Difficulty waking up • Sleepy at inappropriate times • Drowsy driving Cataplexy • Sleep paralysis • Hypnic hallucinations Polypharmacy • Medication side effect • Substance issue • Mental health issue Prior head injury • Prior stroke • Memory impairment • Cognitive difficulty Other:
☐ Parasomnia/ Epilepsy	Sleep walking • Sleep talking • Sleep eating Night terrors • Nightmares Acting out dreams Seizures/spells Other:
☐ Abnormal movements	Restless legs • Nocturnal limb movements • Thrashing Nocturnal myoclonus Other:
☐ Snoring/ Sleep Apnea	Snoring • Witnessed apnea • Clenching or bruxing • Bedpartner complaints Not compliant with CPAP • Interested in alternatives to CPAP Obesity • Long narrow face • Narrow upper airway • Nasal congestion • Enlarged tonsils Treatment resistant HTN • Atrial fibrillation • Diabetes • Metabolic syndrome Other:
☐ Other issues:	Please list:

SERVICE REQUESTED	
☐ Evaluate and Treat	Comments:
☐ Sleep Testing Only (IMPORTANT: chart notes documenting medical necessity required)	☐ Overnight EEG With Report ☐ Home Sleep Apnea Testing (HST) ☐ Diagnostic Polysomnography (PSG) ☐ Daytime sleep testing (MSLT/MWT) ☐ CPAP/BiPAP/ASV Titration (please include chart notes and starting pressure) ☐ Overnight Ambulatory Blood Pressure Monitoring ☐ Other:

Referring provider name (print): _____ **Phone:** _____

Signature: _____ **Date:** _____

Please see back of this form for sleep screening questionnaires

SOUND SLEEP HEALTH
Tel: 425-636-2400
Fax: 425-636-2401

Thank you for choosing Sound Sleep Health! We look forward to participating in your patient's care.

Patient's Name: _____ **Date of Birth:** ____/____/____

PLEASE CIRCLE THE BEST ANSWER TO EACH QUESTION BELOW, USING THE FOLLOWING GENERAL GUIDE:

Never or almost never = once a year or less
Seldom = once a month or less
Occasionally = several times per month on average
Frequently = several times per week on average
Daily or almost daily = more than 5 times per week on average

SVS-i

	HOW OFTEN DO YOU HAVE INSOMNIA OR POOR QUALITY SLEEP?				
	0 Never or almost never	1 Seldom	2 Occasionally	3 Frequently	4 Daily or almost daily
	HOW OFTEN DO YOU WAKE NOT FEELING RESTED?				
	0 Never or almost never	1 Seldom	2 Occasionally	3 Frequently	4 Daily or almost daily
	HOW MUCH ARE YOU IMPACTED BY INSOMNIA OR POOR QUALITY SLEEP?				
	0 Little or no impact		1 Moderate impact		2 Severe impact
Total score:	0 1 No Insomnia	2 3 4 Borderline Insomnia	5 6 7 Moderate Insomnia	8 9 10 Severe Insomnia	

SVS-s

	HOW OFTEN DO YOU HAVE BOTHERSOME DROWSINESS DURING WAKING HOURS?				
	0 Never or almost never	1 Seldom	2 Occasionally	3 Frequently	4 Daily or almost daily
	HOW OFTEN DO YOU WISH YOU COULD TAKE A NAP?				
	0 Never or almost never	1 Seldom	2 Occasionally	3 Frequently	4 Daily or almost daily
	HOW MUCH ARE YOU IMPACTED BY DROWSINESS DURING WAKING HOURS?				
	0 Little or no impact		1 Moderate impact		2 Severe impact
Total score:	0 1 No Drowsiness	2 3 4 Borderline Drowsiness	5 6 7 Moderate Drowsiness	8 9 10 Severe Drowsiness	

GASP-r

	HAVE YOU BEEN TOLD (OR NOTICED ON YOUR OWN) THAT YOU SNORE ON MOST NIGHTS?			
	0 No	1 Yes	1 Not Sure	
	HAVE YOU BEEN TOLD (OR NOTICED ON YOUR OWN) THAT YOU STOP BREATHING OR STRUGGLE TO BREATHE IN YOUR SLEEP?			
	0 No	1 Yes	1 Not Sure	
	DO YOU HAVE ACID INDIGESTION OR HIGH BLOOD PRESSURE (OR USE MEDICATION TO TREAT ANY OF THESE CONDITIONS)?			
	0 No	1 Yes	1 Not Sure	
	ARE YOU OVERWEIGHT?			
	0 No	1 Yes	1 Not Sure	
Total score:	0 1 Low Sleep Apnea Risk	2 Medium Sleep Apnea Risk	3 4 High Sleep Apnea Risk	

Referring provider name (print): _____ **Phone:** _____