Version: SLPQV1

Sleep Consultation

OFFICE USE
Patient ID: ____

NAME: ______________________________

CURRENT DATE: ___/___/_____ ☐ MALE

DATE OF BIRTH: ___/___/_____ ☐ FEMALE

Referring Physician: ______ Contact ID: ______

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

Number
#1 = the most severe symptom

☐ CPAP intolerance

☐ Difficulty falling asleep

☐ Fatigue

☐ Frequent heavy snoring

☐ Frequent heavy snoring which affects the sleep of others

Number
#1 = the most severe symptom

☐ Gasping when waking up

☐ Nighttime choking spells

☐ Significant daytime drowsiness

☐ Sleepiness while driving

☐ Witnessed apneic events

Other: Write In

SLEEP STUDIES

If you have had a Sleep Study, please check one of the following:

☐ Home Sleep Study ☐ Polysomnographic evaluation at a sleep disorder center

Sleep Center Name: ______

Sleep Study Date: __/__/____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of ______

The evaluation showed:

		during REM	*Supine*	*Side*
an RDI of				
an AHI of				

a nadir SpO_2 of ____ T90 ____ ODI ____ (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None

REM Sleep ☐ Decreased ☐ None

Patient Signature: ______ Date: ______