Identification of OSA Patient Name___________________

Part 1. **Immediate Referral**, if any one of these is present (check any that apply)

- Witnessed apneas______________
- Nocturnal arrhythmias___________
- Nocturnal ischemia_____________
- HTN with 3 or medications___________
- Family history of premature death in sleep_____________

Part 2. If yes for 3 or more sign below to refer for sleep study

- Loud snoring__________
- Neck circumference
  - > 17" for men________
  - > 16" for women______
- HTN_________
- Epworth score > 10____________ (see below)
- CHF and any one of the above_________
- Atrial Fibrillation and any one of the above _________

Epworth Sleepiness Scale (ESS)
0= would never doze, 1= slight, 2= moderate, 3= high chance of dozing

Sitting and reading……………………………..____________
Watching TV…………………………………..____________
Sitting inactive in a public place………………____________
Lying down to rest in the afternoon
When circumstances permit……………………____________
Sitting quietly after lunch without alcohol…….____________
In a car, while stopped for a few minutes
In traffic………………………………………_____________

Total_____________

Refer for a sleep study_______________________________ Date________
Signature