

  
**Center For  
Cardiac Sleep Medicine**  
LOUISIANA

Phone: 985-882-9200 \* Fax: 985-882-9090 \* 64040 Hwy 434, Suite 102, Lacombe, LA 70445

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

*We have developed this self-scoring questionnaire as a guideline to help identify sleep disordered breathing problems. Please **check** [✓] the appropriate box if you have experienced any the symptom(s) on a regular basis. Your doctor will discuss these results with your during your visit.*

1. **I have been told that I snore.** [ ]

2. **I have been told that I stop breathing when I sleep, although I may have no recollection of this.** [ ]

3. **I am always sleepy during the day even when I have slept throughout the night.** [ ]

4. **I have high blood pressure.** [ ]

5. **I have been told that I sleep restlessly. I am always "tossing" and "turning".** [ ]

6. **I tend to sweat excessively during my sleep.** [ ]

7. **I frequently awaken with headaches in the morning.** [ ]

8. **I tend to fall asleep during inappropriate times.** [ ]

9. **Others and/or I have noticed a change in my personality.** [ ]

10. **I am overweight.** [ ]

<b>Total Checked [✓] Positive:</b> <span style="float: right;">[ ]</span>
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**SCORING:** If you have **Marked 3 or MORE Boxes**, you show **symptoms of Sleep Apnea**, a life threatening sleep disorder that causes you to stop breathing during your sleep. If you are experiencing any of these symptoms please ask your doctor to refer you to the **Center for Cardiac Sleep Medicine**.

**Physician Sleep Prescription**

**Test(s) Requested:**

[ ] 95810 - Polysomnogram (ie: Sleep Study) & 95811 - CPAP/BiPAP Titration if needed

**Diagnostic Codes:**

[ ] 780.53 - Daytime Sleepiness with Apnea

[ ] Other \_\_\_\_\_

**Special Instructions:** \_\_\_\_\_

\_\_\_\_\_  
Print Physicians Name

\_\_\_\_\_  
Physicians Signature

\_\_\_\_\_  
Date