COFFEE REGIONAL MEDICAL CENTER

NURSING / ANESTHESIA
CRMC Sleep Screening Questionnaire

1ANES

SURGERY:_____ DATE OF SURGERY:_____

PLEASE COMPLETE THE QUESTIONNAIRE TO THE BEST OF YOUR ABILITY. IT WILL BE REVIEWED BY A NURSE AND ANESTHESIA PROVIDER PRIOR TO YOUR SURGERY. THE INFORMATION YOU PROVIDE IS CONFIDENTIAL.

1. SNORING:
Do you ***snore*** loudly (louder than talking or loud enough to be heard through closed doors)?

Yes No

2. TIRED
Do you often feel ***tired***, fatigued or sleepy during daytime?

Yes No

3. OBSERVED
Has anyone ***observed*** you stopping breathing during your sleep?

Yes No

4. BLOOD PRESSURE
Do you have or are you being treated for high blood ***pressure***?

Yes No

5. BMI −
BMI more than 28?

Yes No **BMI Score_____**

6. Age
Age over 50 years old?

Yes No

7. NECK CIRCUMFERENCE
Neck circumference greater than 17 inches for male, 16 inches for female?

Yes No

8. GENDER
Gender −male?

Yes No

SCORE:_____ (Score is number of Yes responses)

❑ **HIGH RISK OF OSA − YES TO SIX (6) OR MORE ITEMS−**
Refer patient to their preferred sleep lab for further study/treatment prior to surgery

❑ LOW RISK OF OSA − YES TO LESS THAN SIX (6) ITEMS

❑ I understand that I am high risk for OSA but refuse further sleep testing and understand that admission after surgery may be necessary.

_____

Patient signature Date/Time

Patient Name and DOB

ANES_9183_EFR
Rev. 07/15/2013