

# Sleep Apnea

Producer \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Client \_\_\_\_\_ Age/DOB \_\_\_\_\_ Sex \_\_\_\_\_

If your client has sleep apnea, please answer the following:

1. Please list date of diagnosis: \_\_\_\_\_

2. Was the sleep apnea diagnosed as:

obstructive

central

unknown

3. How is the sleep apnea being treated?

observation alone      weight loss      other

CPAP/BiPAP mask      surgery

please give details \_\_\_\_\_

4. Is your client on any medications?

yes, please give details \_\_\_\_\_

no

5. What is your client's weight and blood pressure? \_\_\_\_\_

6. Please check if your client has had any of the following:

lung disease      accidents such as motor vehicle accidents

heart disease      arrhythmia

stroke      depression

7. Has your client smoked cigarettes in the last 12 months?

yes

no

8. Please note date of most recent sleep study and attach a copy of the report. \_\_\_\_\_ (date)

9. Does your client have any other major health problems (ex: cancer, etc.)?

yes, please give details \_\_\_\_\_

no