Sleep Apnea Form

Patient Information

Patient's Name				/ /
	First	Last	Middle	

Patient History

	YES	NO	NA
Has the patient had oropharyngeal surgery?	❑	❑	❑
Has the patient had bariatric surgery?	❑	❑	❑
Has the patient had fascial bone surgery?	❑	❑	❑
Has the patient had a tracheostomy?	❑	❑	❑

Dental Appliance

	YES	NO	NA
Does the patient use a dental appliance?	❑	❑	❑
Does the patient tolerate a dental appliance?	❑	❑	❑

Positive Airway Pressure (CPAP, BIPAP & APAP)

	YES	NO	NO
Is the patient treated with CPAP, BIPAP or APAP?	❑	❑	❑
Does the patient tolerate CPAP, BIPAP or APAP?	❑	❑	❑

Annual PAP Device Report

	YES	NO	NA
Does the patient use the PAP device for at least 75% sleep periods?	❑	❑	❑
Does the patient average a minimum of 6 (six) hours of PAP usage per sleep period?	❑	❑	❑
Are there any concerns about adequacy of therapy or non-compliance?	❑	❑	❑

AHI Value

AHI =	❑ NA

Physician Name (Printed)	Physician Signature	Date / /

01 2019