The Art of Dentistry on the main line

1. Have you ever been diagnosed with Sleep Apnea?	No	Yes
If yes, what is your current treatment? CPAPBi-PAP Oral Appliance Other: _____		
2. Do you **snore** loudly (louder than talking or loud enough to be heard through closed doors)?	No	Yes
3. Do you often feel **tired**, fatigued, or sleepy during daytime?	No	Yes
4. Has anyone **observed** you stop breathing during your sleep?	No	Yes
5. Do you have or are you being treated for high blood **pressure**?	No	Yes
6. Body Mass Index (BMI) more than 32?	No	Yes
Height _____ inches/cm Weight _____ lb/kg BMI _____		
(Use the formula to calculate your BMI)		
7. Age over 40 yr old?	No	Yes
8. Neck circumference greater than 40 cm (15 ¾ in)? Unknown	No	Yes
9. Gender male?	No	Yes

SCORING:

High risk of OSA, initiate OSA Order Set:

1. Answering yes to question #1 or #6.

or

2. Answering yes to **four** or more questions

Low Risk of OSA: answering yes to less than four questions.

Questionnaire completed by (Print name, Date / Time)

DISPOSITION (May select more than one)

Attending / Surgeon notified
Sleep Consultation ordered
Patient provided OSA education material (High Risk patients only)

Sleep study on chart

Completed by [Print name, credential(s)] **Date / Time**

Obstructive Sleep Apnea Screening (OSA) Tool