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Home Sleep Study

Patient Name: _____

Home Address: _____

Phone Number: _____

DOB: _____

Ordering Physician: _____

Phone Number: _____ Fax Number: _____

Diagnosis: _____

Test Ordered:

Home Sleep Study (95800)

Physician Signature: _____ Date: _____

NPI: _____

Please send patient demographics, recent chart notes documenting need for sleep study and completed ESS form back with prescription-Thank you!

Patient Name: _____

DOB: _____

Epworth Sleepiness Scale

Find out now if patients' sleepiness is excessive.

The **Epworth Sleepiness Scale (ESS)** is intended to be a tool to help identify a patient's general level of sleepiness. It has 8 routine daytime situations that a patient can rate on a scale from 0 to 3, based on their likelihood of dozing off or falling asleep in each situation. Write the number that corresponds with the answer for each situation in the "MY score" box.

Situation	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	My Score
Sitting and reading	0	1	2	3	
Watching television	0	1	2	3	
Sitting inactive in a public place-exp: meeting or theatre	0	1	2	3	
Lying down to rest in the afternoon when circumstances permit	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch without alcohol	0	1	2	3	
In a car, stopped for a few minutes in traffic	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	

Total Score: _____