Our Physicians:

Michael L. Cohen, M.D.
Harry J. MacDannald, M.D.
Karin Cheung, M.D.
Fred Nachtwey, M.D.
J. Julian Zaka, M.D.

AASM accredited diagnostic sleep center

TEL: (925) 935-7667 FAX: (925) 945-7667
Website: www.ccsleepcenter.com
Email: info@ccsleepcenter.com

Our Locations:

(main location)
1455 Montego, Ste 102
Walnut Creek, CA 94598
(satellite location)
141 Sand Creek Rd, Ste B
Brentwood, CA 94513

This form required because your physician ordered a sleep study evaluation and your insurance requires an authorization. Please complete all of the areas below and send it back to us either by mail or fax so we may begin the authorization process. If you have any questions or concerns, please give us a call at 925 935 7667.

Physician Name:________________________________ Date:______________

Patient Name:____ Date Of Birth:___________

Patient Height:________ Current Weight:_________

---

1. **EPWORTH SLEEPINESS SCALE: Please indicate the likelihood of falling asleep in the following situations by circling the applicable response (0 = no chance, 1 = low chance, 2 = moderate chance, 3 = high chance)**

a. Sitting and Reading	0	1	2	3
b. Watching TV	0	1	2	3
c. Sitting inactive, in a public place (such as a movie theater)	0	1	2	3
d. As a passenger in a car for an hour without a break	0	1	2	3
e. Lying down to rest in the afternoon when circumstances permit	0	1	2	3
f. Sitting and talking to someone	0	1	2	3
g. In a car, while stopped for a few minutes in traffic	0	1	2	3

2. Do you snore? Yes_____ No_____ : if yes, is snoring: (*circle one*) MILD MODERATE SEVERE
3. Does an observer describe pauses in your breathing while asleep? Yes_____ No _____
4. Do you awaken gasping or choking? Yes_____ No_____
5. Do you awaken tired and unrefreshed? Yes_____ No_____
6. Do you have daytime tiredness, sleepiness or fatigue? Yes_____ No_____
7. Do you have restless legs prior to falling asleep? Yes_____ No_____
8. Have abnormal limb movements been described by a sleep observer? Yes_____ No_____
9. Do you have any other sleep related problems? Yes_____ No_____
10. Do you have any special needs during the night? Yes_____ No_____
    If yes, please explain:

11. Have you been diagnosed with any heart or lung disease? Yes_____ No_____
12. Have you ever had a sleep study before? Yes_____ No_____
    If yes, previous study date:_____________
13. List your current prescribed medications: ____

____

(use back of page if you need to list additional medications)

FOR OFFICE USE ONLY: **BMI__________ EPWORTH SCORE:_________**

Approved for: HST IN LAB

Reviewing physician signature:________________________________Date:______________