

Watermark Medical ARES Questionnaire ©

PRINT IN CAPITAL LETTERS - STAY WITHIN THE BOX All Fields Required-unless otherwise specified

Last Name	First Name	Middle Initial	Gender	Male	Female
Date of Birth	Weight	Height	Neck Size		
Month	Pounds	Feet	Inches	Inches	
Day					
Year					
I.D. Number (optional)					

Tally ARES Risk Points

Neck Size
+2 Male ≥16.5
+2 Female ≥15

Score

Co-morbidities
+1 for each Yes response

Score

Do not assign points for these eight responses

COMPLETELY FILL IN ONE SQUARE FOR EACH QUESTION - ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sleep Apnea	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lung disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Nasal oxygen use	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Insomnia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Restless legs syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Narcolepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Morning Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sleep Medication	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pain Medication e.g. vicodin, oxycontin	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of *these things recently, try to work out how they would have affected you.* Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze	1 = slight chance of dozing	0	1	2	3
2 = moderate chance of dozing	3 = high chance of dozing				
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting, inactive, in a public place (theater, meeting, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Epworth Score
Total the values from all 8 questions.
If 11 or less
Score = 0
If 12 or more
Score = 2

Score

Frequency (Check one for each question): Never **+0**, Rarely **+1** times/wk, Sometimes **+2** times/wk, Frequently **+3** times/wk, Almost Always **+4** times/wk.

On average in the past month, how often have you snored or been told that you snored?

Never +0 Rarely +1 Sometimes +2 Frequently +3 Almost always +4

Do you wake up choking or gasping?

Never +0 Rarely +1 Sometimes +2 Frequently +3 Almost always +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never +0 Rarely +1 Sometimes +2 Frequently +3 Almost always +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never Rarely Sometimes Frequently Almost always

Total points for the first three responses

Point Total

I have personally completed this questionnaire.
Signature

Date

Phone Number

Total all 4 boxes from the right side
If points total =3 or lower (no risk)
4 or 5 (low risk), 6 to 10
(high) and 11 or more (very high risk)



Arizona Neurology and Sleep Center
www.azns.org

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At Arizona Neurology and Sleep Center, we are always striving to improve our patient's health by staying current in both our techniques and diagnostic equipment. Recently, we purchased a new technology that we allow you, the patient, to have your sleep study done in the comfort of your own home. Many of our patient's were uncomfortable with the cost and process of outpatient sleep laboratories and we are excited to bring this new, easy to use and economical solution to our patients.

While the monitoring device is in my possession, I agree to exercise care with use and handling, and return it within the promised time frame in working condition. I understand that delays in its return causes problems for other patients who need this service.

FINANCIAL RESPONSIBILITY:

I understand that if the device is lost, stolen or damaged while in my possession, I am responsible to pay Arizona Neurology and Sleep Center for the replacement of this device. The charge for replacing the Home Sleep Test is \$995.00

I am checking this device out on _____ (date) and I agree to return it on _____ (date before 11am) at the conclusion of my sleep test so that other patients may have the same opportunity to be tested as I did. If I do not return it by the date above I agree to to pay \$250.00 per day late fee until the equipment is returned.

Patient Name: _____

Patient Signature: _____

Date: _____



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SLEEP STUDY CONSENT FORM HOME STUDY

- * My Physician has explained the sleep study to me as well as the benefits and risks of having the test performed.
- * I have had the opportunity to ask my physician and my sleep technologist questions, and I consent to the sleep study.
- * I was shown in detail and in-person how to apply the Home Sleep Testing equipment by an AZNS staff as well as given reference materials to take home with me.
- * I will bring back the Home Sleep Testing Equipment the morning after my sleep study or I will be charged for the equipment which could be up to \$2,000.00

Name: _____

Patient Signature: _____

Date: _____ Time _____ AM/PM

Signature of Parent/Conservator/Guardian: _____

Relationship: _____

Hospital/Witness: _____