



PRE PROCEDURE PATIENT SELF ASSESSMENT SLEEP APNEA SCREEN

INSTRUCTIONS: Please complete the information below by checking off which applies to you or symptoms which you experience.

- | | |
|--|---|
| ☐ Snoring | ☐ Neck circumference ≥ 17 inches in men; ≥ 16 inches in women |
| ☐ Excessive daytime sleepiness | ☐ Males ☐ age > 50 |
| ☐ Pause in breathing during sleep | ☐ Body Mass Index (BMI) ≥ 35 (weight in lbs/height in inches ²) |
| ☐ Difficulty falling asleep, insomnia | ☐ Hypertension |

If three or more criteria are checked above speak to your primary care physician, surgeon or the nurse.
If you already have known sleep apnea, bring CPAP headgear and mask to hospital for your procedure.

☐ I currently use CPAP machine and my current setting is: _____

[Signature of Patient/Parent/Conservator/Guardian] [Date] _____ A.M./P.M. [If signed by other than patient, indicate relationship]

Please see chart below to determine your BMI. Circle your height and weight.

BODY MASS INDEX (BMI)											weight in pounds					
BMI →	Ideal			Overweight		Obese					Morbidly Obese					
	20	22	24	26	28	30	32	34	36	38	40	42	44	46	48	50
4' 10"	96	105	115	124	134	144	153	163	172	182	191	201	211	220	230	239
4' 11"	99	109	119	129	139	149	158	168	178	188	198	208	218	228	238	248
5' 0"	102	113	123	133	143	154	164	174	184	195	205	215	225	236	246	256
5' 1"	106	116	127	138	148	159	169	180	191	201	212	222	233	243	254	265
5' 2"	109	120	131	142	153	164	175	186	197	208	219	230	241	252	262	273
5' 3"	113	124	135	147	158	169	181	192	203	215	226	237	248	260	271	282
5' 4"	117	128	140	151	163	175	186	198	210	221	233	245	256	268	280	291
5' 5"	120	132	144	156	168	180	192	204	216	228	240	252	264	276	288	300
5' 6"	124	136	149	161	173	186	198	211	223	235	248	260	273	285	297	310
5' 7"	128	140	153	166	179	192	204	217	230	243	255	268	281	294	306	319
5' 8"	132	145	158	171	184	197	210	224	237	250	263	276	289	303	316	329
5' 9"	135	149	163	176	190	203	217	230	244	257	271	284	298	311	325	339
5' 10"	139	153	167	181	195	209	223	237	251	265	279	293	307	321	335	348
5' 11"	143	158	172	186	201	215	229	244	258	272	287	301	315	330	344	358
6' 0"	147	162	177	192	206	221	236	251	265	280	295	310	324	339	354	369
6' 1"	152	167	182	197	212	227	243	258	273	288	303	318	334	349	364	379
6' 2"	156	171	187	203	218	234	249	265	280	296	312	327	343	358	374	389
6' 3"	160	176	192	208	224	240	256	272	288	304	320	336	352	368	384	400
6' 4"	164	181	197	214	230	246	263	279	296	312	329	345	361	378	394	411
6' 5"	169	186	202	219	236	253	270	287	304	320	337	354	371	388	405	422
6' 6"	173	190	208	225	242	260	277	294	312	329	346	363	381	398	415	433

If patient has CPAP or sleep oximetry order and at main hospital fax to Respiratory Department at x48027

_____ [Print Name of Pre-Procedure RN]	_____ [RN Signature]	_____ [Date]	_____ [Time]
_____ [Print Name of Post-Procedure RN]	_____ [RN Signature]	_____ [Date]	_____ [Time]

CARE PLAN

PS 1724

Rev 08/23/23

Original – Chart

Copy - Patient



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