Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name	Middle Initial	Last Name

Tally ARES Risk Points

Weight	Pounds	**Age**	Years	Gender: **Male** ◯ **Female** ◯
Height	Feet / Inches		**Neck Size**	Inches
Date of Birth	Month / Day / Year		**ID Number**	Optional

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score ☐

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

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

High blood pressure	Yes ◯	No ◯	Stroke	Yes ◯	No ◯
Heart disease	Yes ◯	No ◯	Depression	Yes ◯	No ◯
Diabetes	Yes ◯	No ◯	Sleep apnea	Yes ◯	No ◯
Lung disease	Yes ◯	No ◯	Nasal oxygen use	Yes ◯	No ◯
Insomnia	Yes ◯	No ◯	Restless leg syndrome	Yes ◯	No ◯
Narcolepsy	Yes ◯	No ◯	Morning Headaches	Yes ◯	No ◯
Sleeping Medication	Yes ◯	No ◯	Pain Medication e.g., vicodin, oxycontin	Yes ◯	No ◯

Co-morbidities +1 for each Yes response

Score ☐

Do not assign any points for these eight responses

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**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯
Sitting, inactive, in a public place (theater, meeting, etc)	◯	◯	◯	◯
As a passenger in a car for an hour without a break	◯	◯	◯	◯
Lying down to rest in the afternoon when circumstances permit	◯	◯	◯	◯
Sitting and talking to someone	◯	◯	◯	◯
Sitting quietly after lunch without alcohol	◯	◯	◯	◯
In a car, while stopped for a few minutes in traffic	◯	◯	◯	◯

Epworth Score **TOTAL** the values from all 8 questions,
If 11 or less **Score = 0**
If 12 or more **Score = 2**

Score ☐

Assign points for each of the first three responses

Frequency	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**
On average in the past month, how often have you snored or been told that you snored?	Never ◯	Rarely ◯ +1	Sometimes ◯ +2	Frequently ◯ +3	Almost always ◯ +4
Do you wake up choking or gasping?	Never ◯	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 ◯	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 ◯

☐
☐
☐

Signature	Area Code	Phone Number	**Total all 6 boxes from above**	**Point Total**
			If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	☐

Gay Fulkerson, MD
Family Physician

Dear Patient

It is my privilege to provide you with the best healthcare to prevent and lessen the effects of disease and I remain committed to your comfort, convenience, and satisfaction. I am also committed to offering you the best healthcare at the lowest cost. As such, I would like to share some very important information about Obstructive Sleep Apnea (OSA).

More than 18 million Americans are thought to have OSA. It is a physical condition in which breathing repeatedly stops and starts during the sleep cycle. The result is an interruption in breathing that lasts for at least 10 seconds. It is considered severe when it occurs every two to three minutes.

This letter is intended to make you aware of a very important study about OSA that demonstrated that 46% of people who are undiagnosed with sleep apnea are at risk for a number of life-threatening health problems, such as heart attack, high blood pressure, & diabetes. Yet, four in five people are unaware they have the condition, and are not getting treatment!

Symptoms include:

Loud snoring	Always tired, trouble concentrating and staying awake	Waking with headaches
Waking with a choking sensation	Excessive sweating at night	Waking with dry mouth
Depression	Heartburn	Increased sexual dysfunction
Frequent trips to the bathroom at night	Restless sleep, tossing and turning	Rapid weight gain

Diagnosing OSA used to require an overnight stay in a sleep lab or hospital, attached to wires, in an unfamiliar bed and is rejected by many patients.

Now there is a new FDA approved wireless device that can be worn while you sleep in your own bed, in the comfort of your own home. The sleep study data that is gathered during your sleep is interpreted and I can recommend the best therapy.

For your convenience I am enclosing a brief self-administered survey about Sleep Apnea risk factors. Please take a moment to complete the survey and return it to my office so that I may determine if an appropriate course of action is warranted.

Thank you for allowing me to be part of your healthcare team.

Sincerely,

Gay Fulkerson M.D.

Gay Fulkerson, MD
Family Physician

At Gay Fulkerson M.D. 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 will allow you, the patient, to have your sleep studied in the comfort of your own home. Many of our patients 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.

Unfortunately, not all insurance carriers have updated their policy to include coverage of this new testing solution. It may still be more economical as a non-covered service than being tested in the sleep clinic. Dr. Fulkerson encourages you to explore all options available to you and make the most educated decision that is best for you. If you do choose to move forward with our Home Sleep Test, please read the financial responsibility section below.

FINANCIAL RESPONSIBILTY

I understand that my insurance company is being billed as a courtesy and I agree that I am financially responsible to pay for any charges not covered by my insurance company. The charge for the Home Sleep Test is $ 450.00 .

Patient Name _____

Patient Signature _____

Date _____

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While the monitoring device is in my possession, I agree to exercise care in its 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 RESPONSIBILTY

I understand that if the device is lost, stolen or damaged while in my possession, I am responsible to pay Gay Fulkerson for the replacement of this device. The charge for replacing the Home Sleep Test is $ 650.00 .

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 pay a $ 25.00 per day late fee until the equipment is returned.

Patient Name _____

Patient Signature _____

Date _____