Taylor Regional Hospital

Birthdate: ____/____/____

Name: _____ AKA: _____ Sex: M___ F___
Last First Middle

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____ Do you want to enroll in Patient Portal: YES / NO

Social Security #: _____ Marital Status: Single Married Divorced Life Partner Widow Legally Separated Unknown

Race: African American Asian Bi-Racial Caucasian Hispanic Native American Other Unknown

Ethnicity: Non-Hispanic Hispanic Unknown Religion: _____ Cultural/Religious practices that impact healthcare? YES / NO

Preferred Language: _____ Interpreter required: YES / NO

Patient Employer: _____ Work Phone: _____

Employer Address: _____ State: _____ Zip: _____ Status: FT PT PRN

Does this patient have Custody/Guardianship Papers: YES/NO If YES, PAPERWORK MUST BE ON FILE BEFORE TREATMENT!

If patient is a child, are they in Foster Care? YES/NO If YES, the CPS caseworker MUST sign ALL papers including vaccine & procedure consents.

Healthcare Power of Attorney: YES / NO If Yes, person: _____ Phone: _____

Do you have a durable Power of Attorney: YES / NO If Yes, person: _____ Phone: _____

GUARANTOR INFORMATION – Is the patient responsible for their account? YES / NO If yes, please skip to Insurance Section. If not, please fill out:

Person Responsible for Account: _____ Birthdate: ____/____/____
Last First Middle

Address (if different from patient): _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Email: _____

SN: _____ Relationship to Patient: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Occupation: _____ Status: FT PT PRN

INSURANCE INFORMATION - Do you have VA (Veteran's Administration) benefits? YES / NO

Primary Insurance: _____ Subscribers Name: _____ Subscribers DOB: ____/____/____

Subscribers Relationship to Patient: _____ Subscriber ID: _____ Group #: _____

Effective Date: _____ Is patient covered by additional insurance? YES / NO If No, please skip to Emergency Contact Information.

Secondary Insurance: _____ Subscriber Name: _____ Subscribers DOB: ____/____/____

Subscribers Relationship to Patient: _____ Subscriber ID: _____ Group #: _____

Effective Date: _____

EMERGENCY CONTACT / PERSON TO NOTIFY

Emergency Contact: _____ Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____ Other Phone: _____

Relationship to Patient: _____ Is this person also your Next of Kin? YES / NO If not, please list on next page:

NEXT OF KIN

Next of Kin: _____ Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____ Other Phone: _____

Relationship to Patient: _____

PRIMARY CARE PROVIDER / REFERRING PHYSICIAN

PCP: _____ Phone: _____ Previous PCP: _____

Referring Physician: _____ Phone: _____ Fax _____

Preferred Pharmacy: _____ Phone: _____

STATEMENT OF NON-DISCRIMINATION AND ASSISTNACE AVAILABLE FOR INDIVIDUALS WITH DISABILITIES

In accordance with federal civil rights law, Taylor Regional Medical Group, office, employees, and business associates are prohibited from discriminating based on race, color, national origin, sex, disability, age, or payor source, when providing any clinic service.

At the time of check in, please make the front office staff aware of any of the following:

- Persons with disabilities, who require alternative means of communication during their office visit.
- Individuals who are deaf, hard of hearing or have speech disabilities. These individuals may access the Federal Relay Service at (800) 877-8339.
- Patients with limited English proficiency (LEP). These individuals will have an interpreter provided via CyraCom phone interpretation service.

Signature: _____ Date: _____

Relationship to Patient: _____

Taylor Regional Hospital

PATIENT: _____ DOB: _____

I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding any illness, injury or other health concern affecting me at the time I present to any of Taylor Regional Hospital's Medical Offices for care. These services may include, but are not limited to, laboratory procedures, x-ray examinations, and medical or surgical treatment/procedures.

I have read and understand this agreement. I am the patient, the parent of a minor child, or the legally authorized representative of the patient, and am authorized to act on behalf of the patient and to sign this agreement.

HIPAA

I acknowledge that I have received a copy of the Notice of Privacy Practices (effective September 13, 2013), which explains how my protected health information may be used and disclosed for treatment, payment and health care operations.

SIGNATURE ON FILE

I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

I consent to treatment necessary for the care of the above named patient. I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Taylor Regional Medical Group insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claims.

FINANCIAL POLICY

By signing below, I agree that I have read and fully understand the financial policy set forth by Taylor Regional Hospital's Medical Offices and I agree to the terms of this financial policy. I also understand and agree that the terms of this policy may be amended by the practices at any time without prior authorization to the patient.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO AUTHORIZED REPRESENTATIVES

I give Taylor Regional Hospital and its staff permission to disclose the minimum necessary protected health information to the following designated authorized representative during my visit.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that when requesting disclosure of protected health information, the above name individual(s) must identify me (the patient) by full name, and have knowledge of my birthdate as verification of my identity.

I understand this Authorization can be revoked at any time. Such revocation must be in writing to the Taylor Regional Hospital Privacy Office 1700 Old Lebanon Road Campbellsville KY 42718.

Do we have permission to leave information on your answering machine when you are not home? Yes _____ No _____

_____ _____ _____

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

Taylor Regional Hospital

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

I,_____, parent or legal guardian of

_____

Child's Full Name Date of Birth

do hereby authorize the following individuals (must be over the age of 18) to schedule appointments, and/or accompany my children to medical appointments. Please list anyone other than the child(ren)'s mother, father or guardian who may be accompanying the child(ren) to appointments. This may include siblings over the age of 18, babysitters, step parents, grandparents, neighbors, friends of family, etc. I understand that only my child(ren)'s mother, father, guardian and/or those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunizations) of my teen age 16 and above, in my absence. Authorized individuals include (please print name and relationship):

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Please inform the above listed individuals to bring photo identification to appointments.

Unlisted individuals may obtain treatment for your child(ren) in the case of an emergency. In that case, an attempt to contact you by phone will be made. This authorization will remain in effect until those designated above have their consent revoked in writing.

I have read all of the information above and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Taylor Regional Medical Group of any changes in my health status, my child(ren)'s health status, or the above information. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____

Signature of Parent or Legal Guardian Date

Taylor Regional Hospital

CONSENT TO PRESCRIPTION AND USE OF CONTROLLED SUBSTANCES

I, _____, hereby acknowledge that my medical provider recommends the use of certain controlled substances in the treatment of my medical condition. I understand that the prescription and use of controlled substances is subject to Kentucky law and regulations.

1. I hereby consent to the prescription and use of controlled substances in the treatment of my medical condition, as prescribed by my medical provider.
2. I have been provided information by my medical provider including the following:
    a. How to safely and properly dispose of unused controlled substances;
    b. Proper use of the controlled substance;
    c. The effect of use of controlled substances during pregnancy (if appropriate);
    d. The potential for overdose and appropriate response to overdose; and,
    e. The impact of controlled substances on driving and work safety.
3. It has been explained to me that controlled substances used to treat an acute medical complaint are for time-limited use and that I should discontinue the use of controlled substances, under the direction of my medical provider, when the condition requiring the use of controlled substances has been resolved.
4. I consent to my prescribing medical provider discussing all diagnostic and treatment details with my other healthcare providers, pharmacists, other professionals who provider my healthcare, and with my family regarding my use of controlled substances are listed here:

    _____

    _____

    _____

    _____

    I understand I may revoke this consent or change the approved family members by notifying my medical provider.
5. I understand that if the responsible legal authorities have questions concerning my treatment, as might occur. For example, if I were obtaining controlled substances at several pharmacies, all confidentiality is waived, and I authorize the these authorities may be given full access to my medical records related to my treatment, including controlled substances administration and use.
6. State law requires my medical provider to query and report information to KASPER, the Kentucky database of prescriptions of controlled substances. I understand that my medical provider will query KASPER as part of my care and to confirm my prescriptions and that the KASPER report of information from the KASPER report may be included in my medical record.
7. The risks and potential benefits of the prescribed controlled substances, including, but not limited to, psychological addiction, physical dependence, and withdrawal, have been explained to me and all of my questions have been answered to my satisfaction. These risks and benefits are described in the information attached to the forms and made a part of my medical record.

    I, the undersigned patient of his/her legally authorized representative, attest that the foregoing was discussed with me, and that I have read, fully understand, and consent to the terms of this Consent.

Patient (or legally Authorized Representative): _____ Date/Time: _____

Legally Authorized Representative /Relationship to Patient: _____ Date/Time: _____

Signature of Witness: _____ Date/Time: _____

Taylor Regional Hospital

TAYLOR REGIONAL HOSPITAL
GENERAL AUTHORIZATION TO BE PHOTOGRAPHED AND/OR INTERVIEWED

Name of Participant: _____

I hereby voluntarily authorize Taylor Regional Hospital and/or its parent corporation, subsidiaries, affiliates, agents, contractors, providers or employees ("Entity") to interview and/or take photographs and/or interviews of me. I understand that the term "photograph" may include, but not be limited to, videotape, videodisc, digital image and any other mechanical means of recording or producing visual images ("photographs"). I also understand an interview may involve, but not be limited to, audio tape, or other recording device, podcast, webcast, blog, written recording or other mechanical means or medium to preserve the discussions ("interview material").

I understand and agree that the photographs and/or interview material may also be used and/or disclosed for any and all purposes deemed appropriate by Entity. Such purposes may include, but not be limited to, education, treatment, public relations, advertising, communication materials, promotional, and marketing publications (including postings on Entity's website, podcast, webcast, blog), and/or fundraising activities.

I understand that I may refuse to sign this Authorization, that there is no obligation to participate and applicable treatment, payment, enrollment in any health plan, or eligibility for benefits will not be conditioned upon my providing this Authorization for the use and/or disclosure of my photographs or interview material.

I agree to hold harmless Entity, other third parties designated by Entity, or individuals that are involved in the production, duplication, publication, or any other use and/or disclosure of the photographs, and/or interview material from and against any damages or losses incurred by such use and/or disclosure of the photographs and/or interview material. I also understand that the photographs and/or interview material used and/or disclosed pursuant to this Authorization may be redisclosed by a recipient and such cannot be controlled by Entity.

In addition, I waive all rights to or conditions on the use and/or disclosure of these photographs and/or interview material that I may have and waive any claim for payment or royalties related to the use and/or disclosure of the photographs or interview material (whether such is for charitable or commercial purpose) by Entity or any other party involved in any use and/or disclose now or in the future.

I further understand and agree that these photographs and/or interview material may be used beyond the initial purpose and expiration date, if any listed below, for archival and/or historical purposes by Entity.

Expiration: (Choose one)

This Authorization expires on _____ (Insert date if applicable)

OR

☐ This Authorization expires when no further production, duplication, publication or reprint or any other use of the photographs or interview material is required by Entity.

This Authorization is binding: The statements made in this Authorization are binding, controlling, and I understand that they take precedence over prior statements I have made, including as applicable, those contained in the Taylor Regional Hospital's Notice of Privacy Practices.

Name: _____
(Please Print)

Signature _____ Date: _____

Witness: _____ Date: _____

If the participant is under 18 or unable to grant this Authorization, the guardian or legal representative must provide Authorization by signing below.

I hereby certify that I am the guardian or legal representative of_____ , named above. I give my Authorization without reservation.

Name of Participant's guardian or legal representative:_____

(Please print name of guardian or legal representative)

Signature_____ Date: _____

Witness:_____ Date: _____

THE FOLLOWING IS TO BE USED FOR REVOCATION OF AUTHORIZATION ONLY

Revocation

I understand that I may revoke this Authorization at any time by notifying Taylor Regional Hospital in writing by sending a letter to TRH Public Relations Department, 1700 Old Lebanon Road, Campbellsville, KY 42718 or by completing this Revocation of Authorization form. I understand that if I revoke this Authorization, it will not affect any actions that Taylor Regional Hospital took before it received my revocation letter. For example, Taylor Regional Hospital cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

By signing below, I hereby revoke this Authorization.

Name: _____

(Please print name of participant)

Address: _____

_____

(City/State/Zip)

Signature _____ Date: _____

Witness: _____ Date: _____

For Internal Use Only

Marketing: If the Entity will receive compensation for the use and/or disclosure of the photographs or interview material, the Entity must disclose this to the participant.

When Taylor Regional Hospital is requesting Authorization to use health information for its own use, the following section must be completed and a signed copy must be given to the individual.

Staff Personnel:

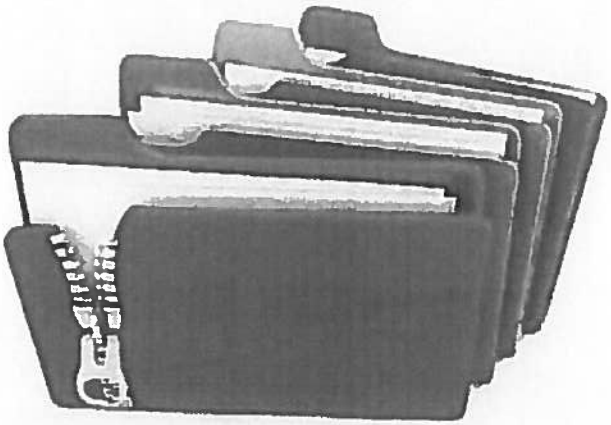
Received by: _____ Date: _____

A signed copy was provided to the individual: ☐ YES ☐ NO

CONS

Taylor Regional Hospital

1700 Old Lebanon Road
Campbellsville, KY 42718
(270) 465-3561
www.trhosp.org



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost based fee
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this • We may say "no" to your request, but we'll tell you why in writing within 60 days
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address • We will say "yes" to all reasonable requests

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations
	  • We are not required to agree to your request, and we may say "no" if it would affect your care
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer
	  • We will say "yes" unless a law requires us to share that information

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make) We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically We will provide you with a paper copy promptly
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information • We will make sure the person has this authority and can act for you before we take any action
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U S Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W , Washington, D C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. • We will not retaliate against you for filing a complaint

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities	*Example: We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind

For more information see **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 9/23/2013

This Notice of Privacy Practices applies to the following organizations.

This Notice applies to Taylor County Hospital District Health Facilities Corporation d/b/a/ Taylor Regional Hospital, Taylor Regional Medical Group, and Taylor Rural Health

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HIPAA Privacy & Security Officer: 270-789-5858
Privacy Hotline: 270-789-6115

ANNOUNCING OUR NEW TAYLOR REGIONAL

PATIENT PORTAL

mychart.trhosp.org

EASY

PORTABLE

CONVENIENT

TIME SAVER

Patient portal is a convenient tool that allows patients to access portions of their electronic medical record (EMR). The Federal Government has issued new guidelines regarding a set of criteria that must be met in using Electronic Health Records referred to as "Meaningful Use". By registering for our patient portal, you are not only benefitting from its convenience, but you are helping us to meet our "meaningful use" requirements.

WHAT CAN I DO ON THE PORTAL?

My personal record – allows you to create a personal medical history that is easy to update. Now your procedures, allergies, or medications are in one central location. The portal makes it convenient to view, update, download, and/or print when needed.

View your health record – view your diagnoses, medications, immunizations, lab and procedure testing results. You can also review discharge instructions provided by your physician. Radiology images are not available on the portal at this time.

Appointments – view, request, change, or cancel appointments at Taylor Regional Hospital and our associated Medical Group facilities. You can also set up email/text reminders so you never miss that important appointment again. You can also transfer them to your existing calendars on your computer or smartphone.

Billing – request itemized billing statements from both our hospital and physician billing departments. Online bill pay is not available at this time.

Share information – Patients can assign proxies who will have access to either view/edit items on their patient portal. Proxies are representatives with which you share your information. This offers a convenient way to keep up with all your family members' medical history.

Create downloadable reports – patients are able to create reports and download them to a personal device, share with others by email, or print your records out at home to take to other appointments.

IS IT SECURE?

Taylor Regional protects your personal information through a series of secure access codes, personal ID's, and passwords. This ensures that only **you** can access your portal information. Please remember to keep your password private.

IS THIS MY COMPLETE RECORD?

Our patient portal offers convenient access to your Electronic Health Record. However, the portal does not substitute for a complete legal medical record. To obtain a complete record, or if you have questions, please contact our Medical Records department at (270) 789-5806 or email us at records@trhosp.org

WHAT DO MY RESULTS MEAN?

Our portal offers a convenient way to take an active role in your healthcare. Any and all results viewed on the portal should be discussed with your physician for a plan of care. Our patient portal should not be a substitute for your physician since they are the experts in evaluating your results and making medical decisions.

HOW DO I REGISTER?

Patient will have a secure code sent to an email address provided to us, and/or a code generated and printed while the patient is at one of our facilities. Results will begin to flow to the patient portal April 3, 2014. Anyone who is not a current patient but has had a visit to our hospital and/or our medical facilities in the past 2 years (2012-current) is able to set up a portal account and begin using it. To register, please call (270) 789-5806.

MODIFIED F.O.S.Q 10 SCALE

Patient Name_____ **D.O.B**_____ **Today's Date**_____

Q1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?
1.Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q2. Do you generally have difficulty remembering things because you are sleepy or tired?
1.Yes , extreme 2. Yes, moderate 3. Yes, a little 4.No

Q3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?
1. Yes, extreme 2. Yes moderate 3. Yes, a little 4. No

Q4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles)
because you become sleepy?
1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q5. Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?
1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q6. Has your relationship with family, friends or work colleagues been affected because you are sleep or tired?
1. Yes, extreme 2.Yes, moderate 3. Yes, a little 4. No

Q7. Do you have difficulty watching a movie or video because you become sleepy or tired?
1. Yes, extreme 2. Yes, moderate 3. yes, a little 4. No

Q8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?
1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?
1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q10. Has your mood been affected because you are sleepy or tired?
1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Score:_____

Taylor Regional Sleep Medicine

Sleep Schedule

Do you nap? Yes ____ No ____
Same daily sleep schedule? Yes ____ No ____
Sleep longer on weekend? Yes ____ No ____
What time do you wake up each day?
What time do you go to bed?
What time do you fall asleep?
How many hours do you sleep?
How many hours of sleep do you need to feel your best,?

Sleep habits:

Do you awake short of breath at night? Yes_____ No_____
Do you snore? Yes_____ No_____
Do you stop breathing at night? Yes_____ No_____
Do you awaken feeling rested? Yes_____ No_____
Do you have excessive day time sleepiness? Yes_____ No_____
Do you have the same sleeping pattern every night? Yes_____ No_____
Are are awakened with leg pain or movement? Yes_____ No_____
Do you walk or talk in your dreams? Yes_____ No_____
Do you have difficulty going to and staying asleep? Yes_____ No_____
Do you sleep 7 hours every night? Yes_____ No_____
While falling asleep do you ever feel paralyzed? Yes_____ No_____
Do you feel temporally paralyzed upon awakening? Yes_____ No_____
Do you ever feel weak when expressing a strong emotion? Yes_____ No_____
If you wake up during night, does it take a long time to fall asleep again? Yes_____ No_____

EPWORTH SLEEPINESS SCALE

0= No chance of dozing 1=Slight chance of dozing
2=Moderate chance of dozing 3=High chance of dozing

Situation	Chance of Dozing(0-3)
• Sitting and Reading	_____
• Watching TV	_____
• Sitting inactive in a public place (e.g. Drs. Office, meeting)	_____
• As a passenger in a car for an hour without a break	_____
• Lying down in the afternoon when possible	_____
• Sitting and talking to someone	_____
• Sitting quietly after lunch without alcohol	_____
• When driving while stopped in traffic for a few minutes	_____
Total	_____

SLEEPINESS SCALE

1-6: Congratulations! You are getting enough sleep!
7-8: Your score is average
9 and above: We are glad you are here