

Epworth Sleepiness Scale

INSTRUCTIONS

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the scale below to rate the likelihood that you would doze off or fall asleep (in contrast to just feeling tired) during that activity. If you haven't done some of these things recently, consider how you think they would affect you. Use the following scale to choose the most appropriate number for each situation.

0 = would never doze

2 = moderate chance of dozing

1 = slight chance of dozing

3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater or a meeting)	
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 a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

If your score is 10 or higher, consider discussing these results with your dentist. Following clinical valuation they may recommend a consult with your Sleep Physician and/or a sleep study for an accurate diagnosis and, if appropriate, effective treatment of an underlying sleep disorder.

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Treatment Consent Form

By signing below I have read and fully understood points 1-7:

1. I have been advised and I understand that snoring can be a symptom of OSA.
2. I accept that SomnoSnore is a treatment for primary snoring ONLY.
3. I have had explained to me the cost of the treatment and I accept responsibility for that cost.
4. I authorize my dentist to provide me with treatment using SomnoSnore.
5. I am aware that this treatment may not be completely effective in treating my primary snoring and is in no way a cure for this condition.
6. I understand that I am responsible for following the written and verbal instructions of my dentist in relation to my SomnoSnore treatment.
7. I will report the occurrence of any side effect to my dentist immediately and seek their advice as to the continued use of SomnoSnore.

Please tick if you agree and understand:

- I have completed an Epworth Sleepiness Scale and my score indicates that I may have a daytime sleepiness problem. Based on this result I have been advised that a sleep study is available to check for the possibility of my having Obstructive Sleep Apnea.

Patient Name:

Patient Signature:

Date:

Witness Name:

Witness Signature:

Date:

Dentist Name:

Dentist Signature:

Date:

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