

 ***Your trusted sleep health provider***

**THE EPWORTH SLEEPINESS SCALE**

*To be eligible for a Bulk Billed Sleep Study please complete this scale (Score 8 or above).*

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**0= No chance of dozing**

**1= Slight chance of dozing**

**2= Moderate chance of dozing**

**3= High chance of dozing**

How likely are you to doze or fall asleep in the following situations, in contrast to feeling just tired?

If you have not done some of these things recently, try to work out how they would have affected you.

|  |  |
| --- | --- |
| **SITUATION** | **CHANCE OF DOZING** |
| Sitting and reading |  |
| Watching TV |  |
| Sitting inactive in a public place |  |
| As a passenger in a car for an hour without a break |  |
| Lying down to rest in the afternoon  |  |
| Sitting and talking to someone |  |
| Sitting quietly after lunch without alcohol |  |
| In the car, stopped at traffic lights for a few minutes  |  |

**TOTAL**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**