Screening Form  ****

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| **Patient information:** |
| Name:  | HSN:    |
| Address:  | Gender: [ ]  male   [ ]  female  | [ ]  Pregnant[ ]  Lactating |
| Telephone:  | DOB: |
| Alcohol use (If yes, how often, how much, when)   [ ]   No [ ]   Yes 🡪 how often, how much, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tobacco use (If yes, how often and when) [ ]   No [ ]   Yes 🡪 how often, how much, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Shift work [ ]   No 🡪 Continue [ ]   Yes 🡪 refer, CBTi usually not appropriate for shift workers |
| **Patient Medical History:** |
| Co-morbid condition which is a contra-indication to CBTi ? [ ]   No 🡪 Continue [ ]   Yes 🡪 refer Symptoms or diagnosis of sleep disorder other than chronic insomnia (e.g. sleep apnea, RLS, narcolepsy, etc.)? [ ]   No 🡪 Continue [ ]   Yes 🡪 CBTi may not be appropriate, referChronic condition(s) that may cause or contribute to sleep disturbances?*(See Tables 1 and 2 in Training Manual)* [ ]   No 🡪 Continue    [ ]   Yes, what condition(s)  🡪 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assess, treat or refer as necessary 🡪 CBTi may still be appropriateAcute condition which may be disturbing sleep (nasal congestion, acute pain, etc)  [ ]   No  → Continue    [ ]   Yes  → Insomnia will likely improve as condition resolves, educate,& monitor |
| **Medication History** |
| Currently using a medication that may be responsible for or contributing to sleep disorder?  [ ]  No 🡪 Continue [ ]  Yes 🡪 Recommend stopping or changing medication if appropriate and/or refer.Recent discontinuation of a medication or other substance associated with withdrawal effects that include sleep disturbances?  [ ]  No 🡪 Continue [ ]  Yes 🡪 Assess and/or referCurrently using a medication for sleep? [ ]   No 🡪 Continue [ ]  Yes 🡪 What medication(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If using sleep medication, does the patient wish to discontinue the medication?  [ ]  Yes 🡪 Continue [ ]  No 🡪 Inform patient eventually stopping hypnotic use is a goal of therapy but they  can reduce use at their own pace |
| **Review of Symptoms:** |
| [ ]   PHQ-9 Patient Depression Questionnaire Score \_\_\_\_\_ If score > 10, refer. *Note: CBTI may still be appropriate.*[ ]   Generalized Anxiety Disorder 7 item (GAD-7) scale Score \_\_\_\_\_  If score > 10, refer. *Note: CBTI may still be appropriate.*[ ]   Insomnia Severity Index (ISI) Score\_\_\_\_\_\_\_0–7 = No clinically significant insomnia 🡪 Sleep education8–14 = Subthreshold insomnia 🡪 Sleep education + sleep hygiene 15–21 = Clinical insomnia (moderate severity) 🡪 CBTi22–28 = Clinical insomnia (severe) 🡪 CBTiDuration of sleep disturbances for at least one month?  [ ]   Yes 🡪 Continue    [ ]   No → Educate on management of acute insomnia, monitorAny other symptom(s) of concern (systemic or mental heath)?  [ ]   Yes 🡪 List symptoms   |
|  **Patient Enrollment** |
| Describe rationale for enrolling patient in CBTi: Provided patient with sleep logs? [ ]  Yes [ ]  No 🡪 Therapy cannot begin without at least one week of sleep log dataIf taking a hypnotic, made arrangements to contact prescriber in regards to tapering the medication [ ]  Yes 🡪 Pharmacist will communicate with prescriber. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  No 🡪 Patient does not wish to reduce hypnotic use at this timeNext appointment: Date: Time: Pharmacist:  |
|  **Pharmacist Completing the Assessment:**  |
| Name: Pharmacy: Tel: Fax: Email:  |
| Signature  | Date:  |