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, refer  Chronic 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 appropriate  Acute 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 refer  Currently 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 education  8–14 = Subthreshold insomnia 🡪 Sleep education + sleep hygiene  15–21 = Clinical insomnia (moderate severity) 🡪 CBTi  22–28 = Clinical insomnia (severe) 🡪 CBTi  Duration of sleep disturbances for at least one month?     Yes 🡪 Continue      No → Educate on management of acute insomnia, monitor  Any 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 data  If 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 time  Next appointment: Date: Time:  Pharmacist: | | | |
| **Pharmacist Completing the Assessment:** | | | |
| Name:  Pharmacy:  Tel: Fax: Email: | | | |
| Signature | | Date: | |