

Post-Sleep Questionnaire

Patient Name: _____ Date: _____

Form completed by: Patient Patient's family Sleep staff

How long did it take you to fall asleep?

- < 15 minutes
- 15 - 30 minutes
- 30 - 45 minutes
- 45 - 60 minutes
- > 60 minutes

How many times did you wake during the night?

- 0 - 1 times
- 2 - 4 times
- 5 - 7 times
- > 7 times

How did you sleep?

- Very restless
- Moderately restless
- Moderately sound
- Very sound

How do you feel now?

- Groggy
- Drowsy
- Moderately awake
- Wide awake

How was your sleep here compared with your sleep at home?

- Much worse
- Worse
- Similar
- Better
- Much better

Comments (note any situation or problem associated with your night's sleep): _____

FOR CLINICIAN USE ONLY – Discharge instructions given: Yes No Time: _____

Physician/NP discharged patient? Yes No Name: _____

Mode of discharge: Ambulate Wheelchair Discharged in care of: _____

Discharged to: Home Other: _____ **Escorted by:** _____

Technologist signature: _____