

Screening Form

| Patient information: | | | |
|--|---|-----------------------------|--|
| Name: | HSN: | | |
| Address: | Gender: □Male □Female □Other | □Pregnant □Breastfeeding | |
| Telephone: | DOB: | | |
| Alcohol use ☐ No ☐ Yes (how often, how much, whe | en) | | |
| Tobacco use ☐ No ☐ Yes (how often, how much, when | en) | | |
| Shift work ☐ No → continue ☐ Yes → refer, Pharm | naZzz therapy unlikely to be effective | | |
| Medical History: | | | |
| Co-morbid condition contra-indication to PharmaZzz (e.g. severe depression, seizure disorder, bipolar disorder)? \square No \rightarrow continue \square Yes \rightarrow refer | | | |
| Symptoms or diagnosis of sleep disorder other than chronic insomnia (untreated sleep apnea, RLS, narcolepsy, etc.)? \Box No \rightarrow continue \Box Yes \rightarrow PharmaZzz therapy may not be appropriate, refer | | | |
| Chronic condition(s) that may cause or contribute to sleep disturbances? (Tables 1 and 2 in Training Manual) □ No → continue □ Yes → what condition(s) Assess, treat, refer if indicated. PharmaZzz therapy may still be appropriate | | | |
| Acute condition which may be disturbing sleep (e.g. nasal congestion, acute pain) □ No → continue □ Yes → insomnia will likely improve as condition resolves, educate & monitor. PharmaZzz therapy not indicated | | | |
| Medication History | | | |
| Currently using a medication that may be responsible for or contributing to sleep disorder? | | | |
| \square No \rightarrow continue \square Yes \rightarrow recommend | stopping or changing medication if appro | priate and/or refer. | |
| Recent discontinuation of a medication or other substance associated with withdrawal effects that include sleep disturbances? | | | |
| \square No \rightarrow continue \square Yes \rightarrow assess and | /or refer | | |
| Currently using a medication for sleep? | | | |
| \square No \rightarrow continue \square Yes \rightarrow list medica | ation(s), dose, duration: | | |
| If using sleep medication, does the patient wish to discontinue the medication? | | | |
| \square Yes \rightarrow continue \square No \rightarrow continue bu | t inform patient this is an eventual goal o | f therapy P.1 | |

| Review of Symptoms: | | | |
|--|--|--|----|
| ☐ Sleep Insomnia Severity Index (ISI) S | | | |
| □ 0 - 7 = No clinically significant □ 8-14 = Subthreshold insomnia □ 15-21 = Clinical insomnia (moderate) □ 22-28 = Clinical insomnia (severate) | → sleep education + sleep lerate severity) → offer Phar | hygiene maZzz therapy | |
| □ Dysfunctional Beliefs and Attitudes a □ ≥ 4 average (total score/16), ≥ less successful; refer to physici | 6 any individual item → mor | nitor, PharmaZzz still appropriate but may b | е |
| ☐ Depression PHQ-9 Score | | | |
| ☐ If 10 or higher →consider referr PharmaZzz therapy may still be | | | |
| ☐ Anxiety GAD-7 Score | | | |
| ☐ If 10 or higher → consider reference PharmaZzz therapy may still be | | | |
| Duration of sleep disturbance? | | | |
| □ Less than 1 month → educate on mana □ 1 - 3 months → consider PharmaZzz th □ More than 3 months → offer PharmaZz | nerapy (e.g., if ongoing hypn | | |
| Other signs / symptom(s) of concern (sy | stemic or mental health)? | | |
| ☐ Yes → List: | • | | |
| | | | |
| Enrollment in PharmaZzz program | | | |
| Describe rationale for enrolling patient: | | | |
| Dravided nations with along loss and instruc | ations on use? | | |
| Provided patient with sleep logs and instruction □ Yes □ No → Therapy cannot begin with the street of the street | | sleep log data (two weeks preferred) | |
| If taking a hypnotic, arrangements made to ☐ Yes → Pharmacist will communicate w | ith prescriber. | s to tapering the medication? | |
| Name of prescriber: □ No → Patient does not wish to reduce | | | |
| | | | |
| Next appointment: Date: | _ Time: | Venue: | |
| Pharmacist Completing the Assessment | t: | | |
| Name: | | | |
| Pharmacy: | | | |
| Tel: | Fax: | Email: | |
| Signature | Date: | P | .2 |