Obstructive Sleep Apnea IRILO Checklist

Name: **Date:**
RANK:
SSN:
DAFSC:

Years Svc: ☐ **< 5 Years** ☐ **> 5 Years** ☐ **≤ 15 Years** ☐ **≥ 15 Years**

Daytime Somnolence: ☐ **Yes (detail)** ☐ **No**

Apnea Episodes: ☐ **Yes (detail)** ☐ **No**

Sleep Study results c/w/ OSA: ☐ **Yes (see attached)** ☐ **No**

BMI:

Oral devices used: ☐ **Yes** ☐ **No**

CPAP required: ☐ **Yes** ☐ **No**

BIPAP required: ☐ **Yes** ☐ **No** **If Yes, STOP No fast Track**

Symptom response to Oral devices/CPAP: ☐ **Controlled** ☐ **Uncontrolled**

Risk for sudden incapacitation: ☐ **Low** ☐ **Moderate** ☐ **High**

_____
Signature/Date

DAWG Review and Recommendation: ☐ **RTD** ☐ **C-1** ☐ **C-2** ☐ **C-3** ☐ **Full**

Recommended follow-up interval: ☐ **3 mo.** ☐ **4 mo.** ☐ **6 mo.** ☐ **Annual** ☐ **Biennial**