

Sleep Specialist's Evaluation Form

Name _____ Date _____

From Primary Information Case history number _____ Case history number _____

Key aspects		
Initial diagnosis		
Matching symptoms		

After reading Secondary Information

Is your initial diagnosis confirmed?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
If no, what is your new diagnosis?		
If no, what caused you to change your diagnosis?		
Recommended treatment		
Expected outcome (effect of treatment on patient symptoms)		