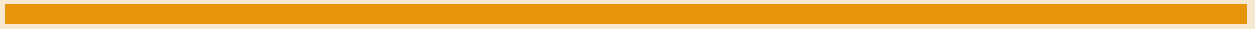


MY ✨  
T.A.S.K.  
JOURNAL ✨



**THIS JOURNAL BELONGS TO:**



**The T.A.S.K. To End Sudden Death  
Treating A Silent Killer**

**Created by**

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**Sudden Cardiac-death Awareness  
Research Foundation**

**2022**

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# WHAT IS SLEEP APNEA?

Sleep apnea is a sleep-related breathing disorder in which the soft palate of the mouth slides back into the throat. This causes an obstruction in the airway and can have serious consequences. You are risking your life every minute that you are asleep, and no one is able to help you. With proper treatment and dedicated compliance, you can change the way you feel, think, and live every day. This journal will help to keep you on track and improve your quality of life!

# SIGNS & SYMPTOMS

## Risk factors can include

- Obesity
- Diabetes
- Gender (male)
- Anxiety
- Depression
- Craniofacial characteristics (small jaw, big tongue, large neck size)

## Symptoms can include

- Fatigue
- Insomnia
- Unexplainable tiredness
- Memory loss
- Snoring

# STOP-BANG QUESTIONNAIRE

There is a high prevalence of OSA, but 90% of the population remains undiagnosed. STOP-Bang was developed to meet the need for a reliable, concise, and easy-to-use screening tool. Use this quiz to determine your level of apnea and share with your loved ones if they have risk factors so you can improve their quality of life as well!

## STOP-BANG Sleep Apnea Questionnaire

*Chung F et al Anesthesiology 2008 and BJA 2012*

<b>STOP</b>		
Do you <b>SNORE</b> loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel <b>TIRED</b> , fatigued, or sleepy during daytime?	Yes	No
Has anyone <b>OBSERVED</b> you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood <b>PRESSURE</b> ?	Yes	No

<b>BANG</b>		
<b>BMI</b> more than 35kg/m <sup>2</sup> ?	Yes	No
<b>AGE</b> over 50 years old?	Yes	No
<b>NECK</b> circumference > 16 inches (40cm)?	Yes	No
<b>GENDER</b> : Male?	Yes	No

<b>TOTAL SCORE</b>		

**High risk of OSA: Yes 5 - 8**

**Intermediate risk of OSA: Yes 3 - 4**

**Low risk of OSA: Yes 0 - 2**



# TREATMENT OPTIONS

## **Oral Appliance:**

- Some are designed to open your throat by bringing your jaw forward, which can sometimes relieve snoring and mild obstructive sleep apnea.

## **Positive Airway Pressure:**

- CPAP: Air pressure is somewhat greater than that of the surrounding air and is just enough to keep your upper airway passages open, preventing apnea and snoring.
- Auto-CPAP: Airway pressure device that automatically adjusts the pressure while you're sleeping.
- BPAP: These provide more pressure when you inhale and less when you exhale.

## **Hypoglossal Nerve Stimulation:**

- This requires surgery to insert a stimulator for the nerve that controls tongue movement.

# IMPORTANCE OF COMPLIANCE

Seeking treatment is always the best option when diagnosed with OSA, but that also applies to following through with the treatment plan. When a treatment option is not properly followed, it can lead to multiple negative results, including:

- Heart Failure
- Coronary Artery Disease
- Strokes
- Type 2 Diabetes
- Some Cancers
- Metabolic Syndrome
- Hypertension
- Atrial Fibrillation
- Death

It is so crucial the treatment plan is followed through, as only 65% to 70% of patients stick to their plan.

# MENTAL HEALTH RESOURCES

If you are struggling, call or text the **suicide prevention hotline** at **9-8-8** to be connected with a counselor.

## Coping Mechanisms:

- ✦ Join support groups on social media platforms
- ✦ Talk to a trusted friend or family member
- ✦ Exercise/yoga
- ✦ Meditation/breathing techniques
- ✦ Journaling/writing down your feelings
- ✦ Use self-help phone applications such as Moodfit, Headspace, and Sanvello

# EMERGENCY CONTACTS

## Any Emergency

9-1-1

## My #

\_\_\_\_\_

## Cardiologist

Name: \_\_\_\_\_

#: \_\_\_\_\_

## Family Member

Name: \_\_\_\_\_

#: \_\_\_\_\_

## Primary Physician

Name: \_\_\_\_\_

#: \_\_\_\_\_

## Family Member

Name: \_\_\_\_\_

#: \_\_\_\_\_

## Other

Name: \_\_\_\_\_

#: \_\_\_\_\_

## Other

Name: \_\_\_\_\_

#: \_\_\_\_\_

## Other

Name: \_\_\_\_\_

#: \_\_\_\_\_

## Other

Name: \_\_\_\_\_

#: \_\_\_\_\_

# APPOINTMENT REMINDERS

Date	Time	Doctor	Location

# HABIT TRACKER

Year: \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

J																																	
F																																	
M																																	
A																																	
M																																	
J																																	
J																																	
A																																	
S																																	
O																																	
N																																	
D																																	

HOW ARE YOU  
FEELING?

Date: \_\_\_\_\_

Dotted lines for writing.

