**SLEEP HEART HEALTH STUDY**

**ADVERSE EVENTS**

1. **Were any of the following *immediate* medical alerts noted?**
   - [ ] YES  [ ] NO  
   - Systolic Blood Pressure > 200 (not on bp meds)
   - Diastolic Blood Pressure > 120 (not on bp meds)
   - Oxygen saturation < 80% for longer than 2 minutes at rest
   - Heart rate > 150 for longer than 2 minutes at rest
   - Heart rate < 30 for longer than 2 minutes at rest

2. **Were any of the following *urgent* medical alerts noted?**
   - [ ] YES  [ ] NO  
   - Systolic Blood Pressure > 170 (not on bp meds)
   - Diastolic Blood Pressure > 100 (not on bp meds)
   - Oxygen saturation between 80% and 85% for longer than 2 minutes at rest

If any alerts were noted:
   - [ ] YES  [ ] NO  
   - Was a physician notified? [ ]  
   - MD Name: ____________  Date: ____________
   - Other action taken: ____________

3. **Were any other problems noted?**
   - [ ] YES  [ ] NO  
   - Skin reaction ____________
   - Tripping, falling ____________
   - Other problem, specify: ____________

Action taken: ____________

**Technician I.D.:** ________

**Date:** ________