

## Downloadable forms at www.sleeptherapeutics.ca

## **Sleep Disorder Referral Form**

Patient Name:			
Phone:		DOB:	
□ Level III Sleep CPAP/APAP therapy if indi	•		CBT for Primary Insomnia  Iew Positional Therapy
<ul> <li>□ Sleep Consult, Level III sleep study</li> <li>□ Existing CPAP patient requiring follow up care</li> </ul>		□ Registered Dietitian Consult □ Shift Work Consult	
Doctor / Practitioner Signature:			
Phone:	Fax:		Date:
Fax Referral To:			
■ North Clinic Fax: 780.758.0123 Phone: 780.758.0020	■ West Clin Fax: 780.4 Phone: 780.	87.9904	■ Wetaskiwin Clinic Fax: 587.651.6593 Phone: 780.387.8762
South Clinic Fax: 780.760.0073 Phone: 780.760.0075	Fax: 780.4 Phone: 780.		

TELESLEEP
A SECURE TELEHEALTH PLATFORM

Convenient online patient care available

## **STOP-Bang Scoring Model**:

A Tool to Screen Obstructive Sleep Apnea.

Name:
<ol> <li>Snoring         Do you Snore loudly (louder than talking or loud enough to be heard through closed doors)? Yes No     </li> </ol>
2. Tired Do you often feel <i>T</i> ired, fatigued or sleepy during daytime? Yes No
<ol> <li>Observed         Has anyone Observed you stopping breathing during your sleep Yes         No     </li> </ol>
4. Blood Pressure Do you have or are you being treated for high blood Pressure? Yes No
5. Body Mass Index  **BMI more than 35kg/m²?  Yes No
6. Age Age over 50 years old? Yes No
7. Neck circumference Neck circumference greater than 40cm / 16 inches Yes No
8. Gender  Gender-male?  Yes No
TOTAL:
High risk of OSA - 'yes' to three or more items  Low risk of OSA - 'yes' to less than three items

Chung, F., Yegneswaran, B., Liao, P., Chung, S. A., Vairavanathan, S., Islam, S., Khajehdehi, A., and Shapiro, C. M. STOP Questionnaire A Tool to Screen Obstructive Sleep Apnea. Anesthesiology 108, 812-821. 2008.