Sleep
THERAPEUTICS

Downloadable forms at
www.sleeptherapeutics.ca

Sleep Disorder Referral Form

Patient Name: _____

Phone: _____ **DOB:** _____

- ☐ **Level III Sleep Study, CPAP/APAP/Bilevel therapy if indicated**
- ☐ **Sleep Consult, Level III sleep study**
- ☐ **Existing CPAP patient** requiring follow up care
- ☐ CBT for Primary **Insomnia**
- ☐ **New Positional Therapy**
- ☐ **Registered Dietitian** Consult
- ☐ **Shift Work** Consult

Additional Information:

_____

_____

Doctor / Practitioner (print): _____

Signature: _____

Phone: _____ **Fax:** _____ **Date:** _____

Fax Referral To:

■ **Charlottetown Clinic**
Fax: 902.482.2355
Phone: 902.628.0101

TELESLEEP
A SECURE TELEHEALTH PLATFORM

Convenient online patient care available

STOP-Bang Scoring Model:

A Tool to Screen Obstructive Sleep Apnea.

Name: _____

1. **Snoring**
   Do you ***S***nore loudly (louder than talking or loud enough to be heard through closed doors)? Yes No

2. **Tired**
   Do you often feel ***T***ired, fatigued or sleepy during daytime?
   Yes No

3. **Observed**
   Has anyone ***O***bserved you stopping breathing during your sleep?
   Yes No

4. **Blood Pressure**
   Do you have or are you being treated for high blood ***P***ressure?
   Yes No

5. **Body Mass Index**
   BMI more than 35kg/m^2?
   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.