



CLINIC:
 Edmonton South (Ellwood)
 Edmonton West (Lynnwood)
 Edmonton North (Hudson)
 Sherwood Park
 Wetaskiwin

ADDRESS:
 #215 236 91 St.
 8748-149 St.
 14066 127 St.
 #217 501 Bethel Dr.
 5109 50 Ave.

PHONE / FAX:
 780.760.0075 / 780.760.0073
 780.487.5355 / 780.487.9904
 780.758.0020 / 780.758.0123
 780.467.3727 / 780.467.3725
 780.387.8762 / 587.651.6593

ALBERTA NORTH - SLEEP THERAPEUTICS	
SLEEP DISORDER AND APNEA REFERRAL FORM	
PATIENT INFORMATION	
Last Name:	First Name:
Address:	
Phone:	
City:	Province:
Postal Code:	
PHN#:	DOB: mm/dd/yyyy
Gender:	
Contact Name:	Contact Phone:
SLEEP APNEA TESTING AND TREATMENT OPTIONS	
<input type="checkbox"/> Level III home sleep apnea test and CPAP/APAP therapy if indicated in sleep study interpretation <input type="checkbox"/> Level III home sleep apnea test only <input type="checkbox"/> Existing CPAP/APAP patient requiring follow-up	
ADDITIONAL OPTIONS	PATIENT COMORBIDITIES
<input type="checkbox"/> CBT for Insomnia/home sleep apnea test <input type="checkbox"/> Sleep Solutions Consultation <input type="checkbox"/> Positional Therapy <input type="checkbox"/> PFT (provided by external partner) <input type="checkbox"/> Other:	<input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Hypertension <input type="checkbox"/> Metabolic Syndrome <input type="checkbox"/> COPD
ADDITIONAL INFORMATION/SPECIAL INSTRUCTIONS/POTENTIAL CONTRADICTIONS	
CLINIC INFORMATION	
Clinic Name:	CLINIC STAMP:
Physician Name (Print):	
Practitioner ID#:	
Signature:	
Phone: Fax:	
Date:	

ACCREDITED WITH THE COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA

This form is available on the following software platforms: MedAccess, Wolf, Health Quest, Accuro, AVA, JUNO
 If you utilize a system that is not listed or are having difficulty locating our form, you can also download @
sleeptherapeutics.ca and/or contact absales@sleeptherapeutics.ca.

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/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.