CLINIC:
Calgary (Brentwood)
Cochrane

ADDRESS:
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403.730.2494 / 403.730.2494
587.316.6547 / 587.316.6547

ALBERTA SOUTH - 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

☐ Level III home sleep apnea test and CPAP/APAP therapy if indicated in sleep study interpretation
☐ Level III home sleep apnea test only
☐ Existing CPAP/APAP patient requiring follow-up

ADDITIONAL OPTIONS	PATIENT COMORBIDITIES
☐ CBT for Insomnia/ home sleep apnea test	☐ Anxiety/Depression
☐ Sleep Solutions Consultation	☐ Hypertension
☐ Positional Therapy	☐ Metabolic Syndrome
☐ PFT (provided by external partner)	☐ COPD
☐ Other:	

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/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.