



Downloadable forms at
www.sleeptherapeutics.ca

Sleep Disorder Referral Form

Patient Name: _____

Phone: _____ DOB: _____

- Level III / PAT Sleep Study, CPAP/APAP/Bilevel therapy if indicated
- Sleep Consult, Level III / PAT sleep study
- Positional Therapy

- Existing CPAP patient requiring follow up care
- CBT for Primary **Insomnia**

Additional Information:

Doctor / Practitioner (print): _____

Signature: _____

Phone: _____ Fax: _____ Date: _____

Fax Referral To:

- **Whitehorse Clinic**
Fax: 867.668.3228
Phone: 867.668.7456



Convenient online patient care available

TELE SLEEP
A SECURE TELEHEALTH PLATFORM

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.