Sleep THERAPEUTICS

Sleep Disorder Referral Form

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Medicare #: _____ Height: _____ Weight: _____ BMI: _____

Email: _____ Phone: _____

- ☐ 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: _____

TELESLEEP
A SECURE TELEHEALTH PLATFORM

Downloadable forms at
www.sleeptherapeutics.ca

CONVENIENT ONLINE PATIENT CARE

STOP-Bang Scoring Model:

A Tool to Screen Obstructive Sleep Apnea.

Name: _____

1. SNORING

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ☐ Yes ☐ No

2. TIRED

Do you often feel tired, fatigued or sleepy during daytime? ☐ Yes ☐ No

3. OBSERVED

Has anyone observed you stopping breathing during your sleep? ☐ Yes ☐ No

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.