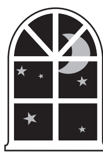

PATIENT REFERRAL FORM

Sleep well, feel well.

35 Baker Drive, Suite 103
Dartmouth, NS B2W 0H3
Tel: 902-435-0298
Fax: 902-435-7259

30 Farnham Gate Rd, Unit 32
Halifax, NS B3M 3W8
Tel: 902-422-1957
Fax: 902-423-4579

91 Sackville Drive, Suite 107
Lower Sackville, NS B4C 2R3
Tel: 902-252-5500
Fax: 902-252-3993

491 Main Street, Unit 2
Kentville, NS B4N 1K9
Tel: 902-365-5875
Fax: 902-365-5874

134 North Street
Bridgewater, NS B4V 2V6
Tel: 902-530-3290
Fax: 902-530-3367

4 Robert Angus Drive, Unit 109
Amherst, NS B4H 4R7
Tel: 902-660-5340
Fax: 902-660-5343

94 Esplanade Street
Truro, NS B2N 1E8
Tel: 902-843-4371
Fax: 902-843-4375

298 Reeves Street, Unit 2
Port Hawkesbury, NS B9A 2B4
Tel: 902-738-3041
Fax: 902-738-3019

295 Charlotte Street Unit 100
Sydney, NS B1P 1C6
Tel: 902-270-7711
Fax: 902-270-2667

** **PLEASE AFFIX PATIENT LABEL IF AVAILABLE** **

Name: ______________________

Address: ______________________

PHONE NUMBERS

Home: ____________ Work: ____________

Cell: ____________

Date of Birth: ____/____/____
DD MM YY

Reason for Referral:

☐ Assess for OSA

☐ Other (symptoms):

____

____

REQUESTED SERVICE

Please note the Home Sleep Study is **FREE** of charge

☐ Home Sleep Study ______________________

☐ CPAP Trial ______________________

Physician/NP: ______________________

Physician/NP Signature: ______________________

Date: ______________________

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STOP-BANG Questionnaire

A tool to screen for Obstructive Sleep Apnea

STOP-BANG Scoring Model

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 the daytime?
   ☐ YES ☐ NO

3. **OBSERVED**
   Has anyone ***observed*** you stop breathing during your sleep?
   ☐ YES ☐ NO

4. **BLOOD PRESSURE**
   Do you have or are you being treated for high blood ***pressure***?
   ☐ YES ☐ NO

5. **BMI**
   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”?
   ☐ YES ☐ NO

8. **GENDER**
   Gender - Male?
   ☐ YES ☐ NO

"YES" to **three or more** items indicates a **high risk** of OSA.

"YES" to **less than three** items indicates a **low risk** of OSA.

Chung F., et al