

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

Is your body mass index more than 35?

_____ Yes _____ No

6. Age

Are you older than 50?

_____ Yes _____ No

7. Neck Circumference

Do you have a neck that measures more than 16 inches (women) and more than 17 inches (men)?

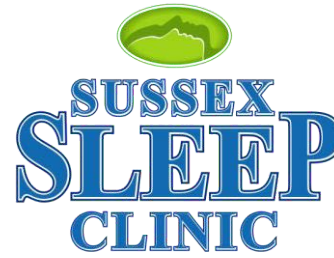
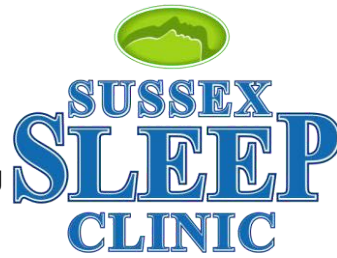
_____ Yes _____ No

8. Gender

Gender = Male?

_____ Yes _____ No

Low risk of OSA: Yes to 0-2 questions	Intermediate risk of OSA: Yes to 3-4 questions	High risk of OSA: Yes to 5-8 questions
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Improving your life one night at a time!

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Date: _____

Referred by: _____

Patient Name: _____

Date of Birth: _____ Medicare Number: _____
DD/MM/YY

Phone Numbers: _____

Home: _____ Work: _____ Cell: _____

Reason for Referral:

Home Sleep Studies, CPAP Trials and CPAP check-ups are FREE of charge

I am referring this patient for a sleep study

I am referring this patient for a sleep study. If the Physician Interpreted study indicates Obstructive Sleep Apnea, please Proceed with CPAP therapy/humidifier and mask.

I am referring this patient for a CPAP Trial

Signature: _____

Please email to sleep@sussexsleepclinic.com or fax this form to 506) 434-0637 and we will be happy to contact your patient promptly.