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:	Intermediate risk of OSA:	High risk of OSA:
Yes to 0-2 questions	Yes to 3-4 questions	Yes to 5-8 questions

SUBMIT

Improving your life one night at a time!

154 Hampton Road - Unit 108 Rothesay, N.B.
E2E 2R3
Tel: (506) 847-5100
Fax: (506) 847-1882
E-Mail: sleep@kvsleepclinic.com
Visit us Online at: kvsleepclinic.com

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@kvsleepclinic.com or fax this form to (506) 847-1882 and we will be happy to contact your patient promptly.