sleepandwake clinic

SELF-REFERRAL

Name: ______________________ DOB: ___/___/______ Age: ________ Gender: ☐ M ☐ F

Address: ______________________ City: ____________ Province: ______ Postal Code: ________

Phone: ______________ Email: ______________________ PHN: ____________

Type of referral

Reason for Referral
- ☐ Routine
- ☐ Urgent

Consultation Services
- ☐ Sleep Medicine
- ☐ Psychiatry (Explain below)

Technical Services
- ☐ Apnea Test
- ☐ In-Lab Sleep Study – requires consultation

Primary Sleep Concerns (Mandatory – Check all that apply)

- ☐ Obstructive Sleep Apnea (Snoring)
- ☐ Insomnia (Non Restorative Sleep)
- ☐ Excessive Daytime Sleepiness (Includes Narcolepsy)
- ☐ Fatigue/Non-Restorative Sleep

Movement Disorders
- ☐ Restless Legs Syndrome
- ☐ Periodic Limb Movement Disorder
- ☐ Sleep Bruxism
- ☐ Other, specify: ____________

Parasomnia
- ☐ Sleepwalking/Night Terrors
- ☐ Violent Sleep Behaviours
- ☐ Nightmares
- ☐ Other, specify: ____________

Additional Information (Safety Sensitive Occupation)

- ☐ Professional Driver
- ☐ Emergency First Responder (EMS/Police/Fire)
- ☐ Other, specify: ____________
- ☐ Airline Pilot/Flight Staff
- ☐ Doctor/Nurse
- ☐ Railroad Engineer/Conductor
- ☐ Oilfield Worker

Pertinent Labs or Physical Findings

Past Medical History

Current Medications

Additional Information

Referring Provider: ______________________ Prac. ID: ______________

Phone Number: ______________________ Fax No.: ______________

Please attach any other pertinent clinical information

sleepandwake clinic

SELF-REFERRAL

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,** (Male), Biological ☐ Yes ☐ No

TOTAL:

High risk of OSA - 'yes' to three or more items

Low risk of OSA - 'yes' to less than three items

Minor Risk Factors

☐ Morning Headache

☐ Nocturnal Reflux

☐ TMJ Issues

☐ Morning Nasal Congestion

☐ Frequent Washroom Breaks

☐ Dry mouth after waking up

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.

sleepandwake clinic

EPWORTH SLEEPINESS SCALE

This scale is used to determine a person's level of daytime sleepiness.
In the following situations, what is your likelihood of falling asleep or dozing?
Answer using this scale:
0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

SITUATION	CHANCE OF DOZING OR SLEEPING
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a car for an hour	
Lying down in the afternoon	
Sitting and talking to someone	
Stopping for a few minutes in traffic while driving	
Total Epworth score	

What was your score?
0-6: You are getting sufficient sleep.
7-9: An average score; you are occasionally sleepy during the day.
10 or higher: You are not getting sufficient sleep.

If you scored 10 or higher, there is a likelihood for the presence of excessive daytime sleepiness, talk to your doctor or a sleep physician.