



NEVADA HEART & VASCULAR CENTER



STOP-BANG SCORING MODEL Screening for Obstructive Sleep Apnea

Patient Name: _____ DOB: ___/___/___ Today's Date: ___/___/___

Patient primary contact phone #: _____ Secondary phone #: _____

Primary insurance: _____ Secondary insurance: _____

ANSWER THE FOLLOWING QUESTIONS TO FIND OUT IF YOU ARE AT RISK FOR OBSTRUCTIVE SLEEP APNEA.

S (Snoring)

Do you snore loudly (louder than talking or loud enough to be heard through closed doors?)

YES NO

T (Tired)

Do you often feel tired, fatigued, or sleepy during daytime?

YES NO

O (Observed)

Has anyone observed you stop breathing in your sleep?

YES NO

P (Blood Pressure)

Do you have or are you being treated for high blood pressure?

YES NO

B (BMI)

BMI more than 35 kg/m²?

YES NO

*For imperial conversion use lb/in² x 705¹

¹Stensland SH and Magolis S. J Am Diet Assoc 1990; 90(6): 856.

A (Age)

Age over 50 years old?

YES NO

N (Neck Circumference)

Neck circumference greater than 40cm (16 in)?

YES NO

G (Gender)

Gender male?

YES NO

High Risk of OSA: answering YES to three or more items

Low Risk of OSA: answering YES to less than three items

(Anybody at high risk and those with low risk in the presence of compelling clinical suspicion of a sleep disorder should be evaluated for a potential sleep disorder)

No indication for referral to sleep center. **Referral to sleep center indicated. See below**

Complete section below and fax to **Zeeba Sleep Center at 702-462-5048**. Thank you for trusting Zeeba Sleep Center to assist in the care of your patients.

Please evaluate the above named patient for potential sleep disorder. Forward the results of all testing to my office at fax #: _____ and treat patient as appropriate based on testing results.

Referring Provider: _____

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SIGNATURE