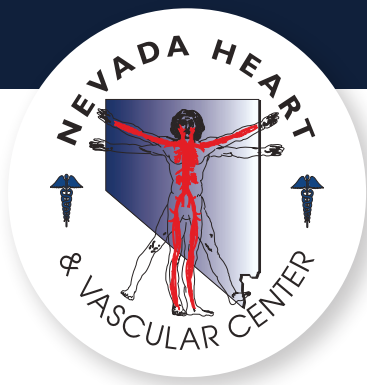


SLEEP CENTER REFERRAL FORM



STATUS: STAT URGENT (within 48 business hrs) STANDARD

DATE: _____

PHONE: (702) 685-9246

FAX: (702) 492-1978

First Name	Last Name	DOB	Age	Home Phone
Cell Phone	SS#	Insurance	Auth	

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?)	<input type="checkbox"/> YES <input type="checkbox"/> NO
T (TIRED)	Do you often feel tired, fatigued, or sleepy during the daytime?	<input type="checkbox"/> YES <input type="checkbox"/> NO
O (OBSERVED)	Has anyone observed you stop breathing in your sleep?	<input type="checkbox"/> YES <input type="checkbox"/> NO
P (BLOOD PRESSURE)	Do you have or are you being treated for high blood pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO

B (BMI)	BMI more than 35kg/m ² ? <small>*For imperial conversion use lb/in²*705¹ ¹Stensland SH and Magolis S. J Am Diet Assoc 1990, 90(6): 856</small>	<input type="checkbox"/> YES <input type="checkbox"/> NO
A (AGE)	Age over 50 years old?	<input type="checkbox"/> YES <input type="checkbox"/> NO
N (NECK CIRCUMFERENCE)	Neck circumference greater than 40cm (16in)	<input type="checkbox"/> YES <input type="checkbox"/> NO
G (GENDER)	Gender Male	<input type="checkbox"/> YES <input type="checkbox"/> 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 to a potential sleep disorder.)

NO INDICATION FOR REFERRAL TO SLEEP CENTER

REFERRAL TO SLEEP CENTER INDICATED

2839 St. Rose Parkway, Suite 160 Henderson, Nevada 89052
7455 W. Washington Ave, Suite 420 Las Vegas, Nevada 89128

Adapted from Chung F et al. Anesthesiology 2009; 108(5):812-21.