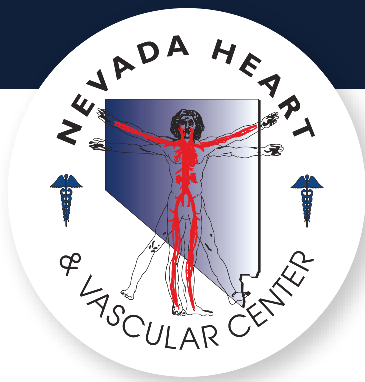

SLEEP CENTER REFERRAL FORM

STATUS: ☐ STAT ☐ URGENT (within 48 business hrs) ☐ STANDARD

DATE:________________

PHONE: (702) 685-9264
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?	☐YES	☐NO
T (TIRED)	Do you often feel tired, fatigued, or sleepy during the 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 35kg/m^2*? *For imperial conversion use lb/in^2×705[1] [1]Stensland SH and Magolis S. J Am Diet Assoc 1990, 90(6): 856	☐YES	☐NO
A (AGE)	Age over 50 years old?	☐YES	☐NO
N (NECK CIRCUMFERENCE)	Neck circumference greater than 40cm (16in)	☐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 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.