Please complete the following questionnaire on behalf of patient

STOP Questionnaire (please tick)

Do you snore loudly (louder than talking/can be heard through a closed door)?	O YES O NO
Do you often feel tired, fatigued or sleepy during the day?	O YES O NO
Has anyone noticed you stop breathing during your sleep?	O YES O NO
Do you have or are you being treated for high blood pressure?	O YES O NO

Recommendations

Patients answering YES to two or more of the above questions are at high risk of having OSA and should be referred directly for an at home sleep study. Patients answering YES to less than two questions should be referred to a sleep specialist consultation in order to determine the necessity for further investigation.

Reference: STOP Questionnaire (Chung F et al, Anaesthesiology. May 2008; 108(5):812-21).

Relevant Medical Conditions (please tick)

O Atrial fibrillation
O CCF
O Depression
O Overweight/obesity
O Pacemaker
O Restless Legs
O Smoker
O Type 2 Diabetes

Type of Study (please tick)

O Home sleep study
O CPAP trial

Relevant Clinical History/Medications (please tick)

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Please turn over…

BOC site ID: ....

[Contact details]

Sleep Referral Form

Original

Date: / /

(Valid for 12 months from date of referral)

Patient Details

Name:

Address:

Phone:

Mobile:

DOB: / /

Gender: ○ MALE ○ FEMALE

Commercial Licence (if applicable): ○ YES ○ NO

Doctor's Details

Name:

Address:

Phone:

Fax:

Provider No:

Signature:

Please stamp if available:

BOC site ID:

[Insert logo]

[Contact details]