## Please complete the following questionnaire on behalf of patient

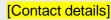
## STOP Questionnaire (please tick)Do you snore loudly (louder than talking/can be heard<br/>through a closed door)?O YESO NODo you often feel tired, fatigued or sleepy during the day?O YESO NOHas anyone noticed you stop breathing during your sleep?O YESO NODo you have or are you being treated for high blood pressure?O YESO 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)				
<ul><li>O Atrial fibrillation</li><li>O CCF</li><li>O Depression</li></ul>	<ul><li>O Overweight/obesity</li><li>O Pacemaker</li><li>O Restless Legs</li></ul>	O Smoker O Type 2 Diabetes		
Type of Study (please tick)				
O Home sleep study	O CPAP trial			
Relevant Clinical History/Medications (please tick)				
		Please turn over		



Sleep Referral F	Date: / / (Valid for 12 months from date of referral)
Patient Details	
Name:	
Address:	
Phone: Mobile	
DOB: / / Gende	er: O MALE O FEMALE
Commercial Licence (if applicable): O YES O NO	
Doctor's Details	
Name:	

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Name:	
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Provider No:	
Signature:	Please stamp if available:
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