Patient Screening for Obstructive Sleep Apnea

ST. MARY'S HEALTH SYSTEM
A Member of Covenant Health

Please answer the following questions to find out if you are at risk for Obstructive Sleep Apnea.

STOP:

SNORE	Have you been told that you snore?	YES	NO
TIRED	Are you often tired during the day?	YES	NO
OBSTRUCTION	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	YES	NO
PRESSURE	Do you have high blood pressure or on medication to control high blood pressure?	YES	NO

BANG:

BMI	Is your body mass index greater than 35? (See BMI chart, included on page 3)	YES	NO
AGE	Are you 50 years old or older?	YES	NO
NECK	MEN: Is your neck circumference (collar size) greater than 17 inches?	YES	NO
	WOMEN: Is your neck circumference greater than 16 inches?	YES	NO
GENDER	Are you male?	YES	NO

If you have answered YES to 3 or more questions, please fill out the following. If you need help with this form, please ask your healthcare provider or staff member for assistance.

PATIENT NAME: _____ DATE OF BIRTH: _____
Please print

PATIENT PHONE #: _____ WEIGHT _____ lbs. HEIGHT: _____ inches

Please do not write below this line – Office use only

PHYSICIAN ORDER REQUEST - FOR REVIEW BY ST. MARY'S CENTER FOR SLEEP DISORDERS PHYSICIAN
(Primary Care Physician office only)

Please attach any pertinent lab, history or exam reports and a list of current medications to assist us in the care of your patient. We will schedule your patient for an appointment with the sleep physician to review the results of their test.

REFERRING PHYSICIAN: _____

PHONE _____ FAX # _____

ADDRESS: _____

TEST REQUESTED: Diagnostic Polysomnography	YES	NO	OTHER?
If required, should oxygen be administered to the patient?	YES	NO	
If yes, the maximum amount of oxygen to be administered is:	_____ liters/minute		
Can patient self-administer their medications?	YES	NO	
Does your patient have or require special needs?	YES	NO	
If yes, please explain: _____			

ST. MARY'S CENTER FOR SLEEP DISORDERS

Patient is approved for testing	YES	NO
More patient information is required	YES	NO

Sleep Physician's Signature _____ Date: _____