Sleep Apnea Screening

Date: ______________________________

Height: ____________________ Weight: ____________________ BMI: __________________

Neck Circumference: ____________________ (men 17"/women 16" showing possible risk for OSA)

Have you ever had a formal overnight sleep study? Yes No

If yes, Where? ____________________________________ Date of Study: ____________________

Screening Protocols Utilizing the STOP/BANG Questionnaire Methodology

The STOP/BANG questionnaire has been shown to have adequate reliability and specificity in identifying patients with sleep-disordered breathing. The following is for each section (S.T.O.P. and B.A.N.G.):

S.T.O.P.

1. Do you **S**nore loudly? Yes / No
2. Do you often feel **T**ired, fatigued or sleepy during daytime? Yes / No
3. Has anyone **O**bserved you stop breathing during sleep? Yes / No
4. Do you have or are you being treated for high blood **P**ressure? Yes / No

(If answering 'yes' to two or more of these questions the patient may be at risk for OSA and needs further assessment and possible diagnose/treat order)

B.A.N.G.

5. **B**MI
   Is BMI over 35? Yes / No

6. **A**ge
   Age over 50 years old? Yes / No

7. **N**eck Circumference (M>17") (F>16")
   Is neck circumference greater than 40 cm? Yes / No

8. **G**ender
   Male gender? Yes / No

Add "yes" answers for numbers 1-8.

High risk of OSA: answering yes to three or more items (particularly if 2 "yes" in the STOP category)

Low risk of OSA: answering yes to less than three items

Risk assessment value: High Risk / Low Risk

Notes: (does patient have a bed partner, reliable historian, etc.)

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Recommendations:

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Faxed to Primary Care Provider? **Yes** or **No** Date Faxed______________________________________

RT – New 112014

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Patient Identification