RESPIRATORY HOMECARE SOLUTIONS

Occupational Sleep Apnea Assessment & Referral Form

Sleep Diagnostics & Therapy | Oxygen Therapy | Pulmonary Diagnostics

Phone: 800-961-6456
Fax: 877-778-8531
rhscanada.com

Patient Information

Last Name: _____
First Name: _____
Sex ☐ M ☐ F | Date of Birth (mm/dd/yy): _____
Address: _____
_____

Company: _____
Phone (Daytime): _____
Phone (Work): _____
Phone (Cell): _____
Email: _____
Health Card #: _____

☐ Sleep Apnea Diagnostic Testing - CPAP Trial/Treatment As Per Occupational Protocol (Please refer to the table on page 119 of the CSS position paper of Obstructive Sleep Apnea and Driving), Oral Appliance, Spirometry and/or referral to sleep specialist/PSG

☐ Other: (PFT, Spirometry, ABG, O2 Assessment, ABPM)

STOP BANG ASSESSMENT

1. Do you **snore** loudly?	YES / NO
2. Do you often feel **tired**, fatigued, or sleepy during day?	YES / NO
3. Has anyone **observed** you stop breathing during sleep?	YES / NO
4. Do you have or are you being treated for high blood **pressure**?	YES / NO
5. BMI more than 35 kg/m2?	YES / NO
6. Age over 50 years old?	YES / NO
7. Neck circumference greater than 40 cm?	YES / NO
8. Gender male?	YES / NO

If the employee has sleep apnea symptoms, referral for testing is recommended

Medical Hx / Notes _____
_____

Referring Physician/Practitioner Information

☐ Please confirm receipt of fax

Name: _____
Signature: _____
Prac ID: _____

Date: _____
Fax Mandatory: _____
Phone: _____
Clinic: _____

Patient consents to further testing: ☐ YES ☐ NO

Patient signature: _____

Office Use Only

Appointment Date: _____ Time: _____

Revised: 18.05.2017
Reviewed by: A.Richards, T.Drapper