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 **Snore** loudly?   Yes   /   No
2. Do you often feel **Tired**, fatigued or sleepy during daytime?   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

(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. **BMI**
   Is BMI over 35?   Yes   /   No

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

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

8. **Gender**
   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.)

______________________________________________________________________________________________________________________________________________________________

______________________________________________________________________________________________________________________________________________________________

**Recommendations:**

______________________________________________________________________________________________________________________________________________________________

Faxed to Primary Care Provider?   Yes   or  No   Date Faxed__________________________________________

RT – New 112014