

PHYSICIANS' CHECKLIST ON SLEEP APNEA RISK FACTORS

Referring Physician: _____

Patient: _____ Date: _____

_____ **OVERWEIGHT** (high BMI)

_____ **NECK CIRCUMFERENCE MORE THAN 16"**

_____ **HIGH BLOOD PRESSURE**

_____ **SNORING**

(CAUTION: NOT ALL SNORERS ARE SLEEP APNEIC, NOT ALL SLEEP APNEICS SNORE)

_____ **HIGH SCORES IN DAYTIME AND NIGHTTIME SLEEPINESS FORMS**

_____ **NOCTURIA**

_____ **RETRUDED MANDIBLE** (JAW TOO FAR BACK)

_____ **SCALLOPED TONGUE** (IMPRINTS OF TEETH ON LATERAL EDGES OF TONGUE)

_____ **LOW PHARYNGEAL ARCH**

(THROAT HARDLY VISIBLE WHEN MOUTH WIDE OPEN WITH TONGUE EXTENDED)

_____ **ADULT DIABETES**

_____ **GERD (GASTROESOPHAGEAL REFLUX)**

Based on the above findings, I hereby refer the above patient to obtain a sleep study to investigate and verify existence and grade of severity of obstructive sleep apnea.
