

# Sleep Study Referral

TO BE COMPLETED BY THE REFERRER



First Name	Surname	NHI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	Town/City	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Email	Phone	Date of Birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
		Gender
		<input type="text"/>

Test Required

<b>Clinical Info</b>	<b>Comorbidities</b>
<input type="checkbox"/> Snoring	<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Daytime Lethargy / Sleepiness	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Nocturnal Gasping / Choking	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Witnessed Apnoeas	<input type="checkbox"/> Cardiac Failure
<input type="checkbox"/> Unrefreshing Sleep	<input type="checkbox"/> Depression
<input type="checkbox"/> Insomnia	<input type="checkbox"/> COPD
<input type="checkbox"/> Restless Legs	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Other

Referrer's Name

Brief Clinical History / Reason for the Sleep Study

Medical History

STOP-Bang Questionnaire		Yes	No
1	<b>Snoring:</b> Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	<input type="checkbox"/>	<input type="checkbox"/>
2	<b>Tired:</b> Do you often feel fatigued, or sleepy during daytime?	<input type="checkbox"/>	<input type="checkbox"/>
3	<b>Observed:</b> Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
4	<b>Blood Pressure:</b> Do you have or are you being treated for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
5	<b>BMI:</b> BMI more than 35 kg/m2?	<input type="checkbox"/>	<input type="checkbox"/>
6	<b>Age:</b> Age over 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>
7	<b>Neck circumference:</b> Neck circumference greater than 40cm?	<input type="checkbox"/>	<input type="checkbox"/>
8	<b>Gender:</b> Gender Male?	<input type="checkbox"/>	<input type="checkbox"/>
Total		<input type="text"/>	/8

Epworth Sleepiness Scale		Score each question (0, 1, 2, or 3)
- What is your chance of dozing in these situations?		
1	Reading	<input type="text"/>
2	Watching TV	<input type="text"/>
3	Sitting inactive in a public place (e.g. cinema, meeting)	<input type="text"/>
4	As a passenger in a car for an hour without a break	<input type="text"/>
5	Lying down resting in the afternoon when circumstances permit	<input type="text"/>
6	Sitting and chatting to someone	<input type="text"/>
7	Sitting quietly after lunch (not having had alcohol)	<input type="text"/>
8	In a car when you stop in traffic for a few minutes	<input type="text"/>
SCORING: 0 - Would never doze 1 - Slight chance of dozing 2 - Moderate chance of dozing 3 - High chance of dozing		Total <input type="text"/> /24

Please tick ☒ clinic location

<input type="checkbox"/> New Plymouth	<input type="checkbox"/> Rotorua	<input type="checkbox"/> Whanganui	<input type="checkbox"/> Palmerston North	<input type="button" value="SUBMIT"/>
20 Robe Street, New Plymouth 4310 T: 06 927 4925 E: bookings@cardioscan.co.nz	1238 Haupapa Street, Rotorua 3010 T: 07 242 7225 E: lakes@cardioscan.co.nz	163 Wicksteed Street, Whanganui, 4500 T: 06 347 9220 E: whanganui@cardioscan.co.nz	91 Milson Line, Unit 4, Roslyn, Palmerston North 4414 T: 06 280 1369 E: midcentral@cardioscan.co.nz	