

Sleep Study Referral

TO BE COMPLETED BY THE REFERRER



First Name	Surname	NHI
Address	Town/City	Postcode
Email	Phone	Gender

Do you have Private Health Insurance? ☐ Yes ☐ No

Test Required	Clinical Info	Comorbidities		
	☐ Snoring	☐ Unrefreshing Sleep	☐ Atrial Fibrillation	☐ Depression
	☐ Daytime Lethargy / Sleepiness	☐ Insomnia	☐ Stroke/ TIA	☐ COPD
	☐ Nocturnal Gasping / Choking	☐ Restless Legs	☐ Hypertension	☐ Diabetes
	☐ Witnessed Apnoeas		☐ Cardiac Failure	☐ Other
Referrer's Name				
Brief Clinical History / Reason for the Sleep Study		Medical History		

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

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

Please tick ☒ clinic location

☐	☐	☐	☐
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