Sleep Study Referral

TO BE COMPLETED BY THE REFERRER

CardioScan Aotearoa

First Name

Surname

NHI

Address

Town/City

Postcode

Date of Birth (DD/MM/YYYY)

Email

Phone

Gender

Test Required

Clinical Info

- ☐ Snoring
- ☐ Daytime Lethargy / Sleepiness
- ☐ Nocturnal Gasping / Choking
- ☐ Witnessed Apnoeas
- ☐ Unrefreshing Sleep
- ☐ Insomnia
- ☐ Restless Legs

Comorbidities

- ☐ Atrial Fibrillation
- ☐ Stroke/ TIA
- ☐ Hypertension
- ☐ Cardiac Failure
- ☐ Depression
- ☐ COPD
- ☐ Diabetes
- ☐ 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

- What is your chance of dozing in these situations?

Score each question (0, 1, 2, or 3)

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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