SLEEP SA

NORTH EASTERN
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_____ ☐

SLEEP STUDY REQUEST FORM

Patient Details

Surname: _____ Given Name(s): _____

Address: _____

Birth Date: _____ Email: _____

Telephone: (Home): _____ (Work): _____ (Mob): _____

Study Date: ___ /___ /___ **Follow-up Date:** ___ /___ /___ by: _____

Health Fund: _____ Fund No: _____ Medicare No: _____

Review By Sleep Specialist Post-Study: Yes: ◯ No: ◯ Report Format: Print: ◯ PDF: ◯

Clinical Details / Indication for study

Test Required

☐ Diagnostic Laboratory
☐ CPAP Titration
☐ Other _____

Level of Assistance/Nursing Care Required Overnight (Important To Facilitate Best Care)

For Referring Dr/GP Only

Appointment with sleep scientist to go through sleep study report: Yes: ◯ No: ◯

Referring Doctor's Details

Name: _____
Address: _____
_____
Telephone: _____
Email Address: _____

Additional Copies to

Name: _____
Address: _____
_____
_____
_____

Doctor's Signature: _____ Date: ___ /___ / ___

Name: ..... **Age:** ..... **years**

Height: ..... **cm** **Weight:** ..... **kg** **BMI:** .....

STOP-BANG Questionnaire*

Please complete		Tick if YES
S	Do you Snore loudly?	☐
T	Do you often feel Tired, fatigued or sleepy during the daytime?	☐
O	Has anyone noticed your breathing is Obstructed during sleep?	☐
P	Do you have or are you being treated for high blood Pressure?	☐
B	BMI more than 35?	☐
A	Age over 50?	☐
N	Neck circumference over 40cm?	☐
G	Gender male?	☐

*Patients answering **YES to 5 or more** of the above questions are at **HIGH RISK of having sleep apnoea** and may be referred for a sleep study. The Epworth Sleepiness scale may also be used to further determine the necessity for investigation.*

**Chung F et al., Chest. 2016; 149(3):631-8*

The Epworth Sleepiness Scale

Based on your recent life-style, how likely are you to fall asleep in the following situations, in contrast to just feeling tired? Even if you have not experienced some of the following situations lately, please try to determine how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = light chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING (0-3)
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theatre or a meeting)	
A passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car while stopped for a few minutes in traffic	
Total Score	

A score ≥ 9 indicates excessive daytime sleepiness

Medication

Tick if YES

Anti-depressant?	☐	**Benzodiazepine?**	☐
Narcotic analgesic?	☐	**Mood stabilizer?**	☐
Anti-convulsant?	☐	**Anti-hypertensive?**	☐
Anti-Parkinson?	☐	**Anti-arrhythmic?**	☐