SLEEP STUDY REFERRAL

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PATIENT DETAILS

Name: Telephone 1:

Address: Telephone 2:

Email:

Medical Aid No : DOB: Health Fund:

SERVICE REQUESTED

Diagnostic Sleep Study – to confirm diagnosis of Obstructive Sleep Apnea and specialist consultation where deemed appropriate by the sleep physician.

Clinical history:

Important: Please complete the 3 following questionnaires to assist in the assessment of your patient.

1. Medical Co-Morbidities (Please complete as appropriate)

Height (cm = Weight (kg) = BMI (kg/m2) =	☐Type 2 Diabetes ☐AF ☐Cardiac Failure ☐Stroke/TIA ☐COPD Other Co-Morbidities:	Previous sleep study: ☐Yes ☐No Date:

2. STOP-BANG Questionnaire (Please Tick)

- ☐ S – Does the patient SNORE loudly?
- ☐ T – Does the patient often feel TIRED, fatigued or sleep during daytime?
- ☐ O – Has anyone OBSERVED the patient stop breathing during sleep?
- ☐ P – Does the patient have or is the patient being treated for high blood PRESSURE?
- ☐ B – Does the patient have a BMI more than 35?
- ☐ A – AGE over 50 years old
- ☐ N – NECK circumference (shirt size) more than 40cm/16 inches
- ☐ G – Is the patient a MALE?

TOTAL SCORE

New guidelines require careful patient screening prior to determining the most appropriate test/consultation. Direct testing may be appropriate if the patient has a high probability for moderate-severe OSA: Epworth Sleepiness Scale of 8 or more and a score of 4 or more on a validated STOP BANG questionnaire.

3. Epworth Sleepiness Scale Questionnaire

For the 8 situations in the table below, how likely is the patient to dose off or fall asleep, in contrast to feeling just tired? Even if the patient has not done some of these things recently, ask them how the situations would have affected them.

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

0 = Would never doze, 1 = slight chance of dozing, 2 = moderate chance of dozing, 3 = high chance of dozing. Then total the scores.

Scenario	Tick one score for each scenario			
Score	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive in a public place (eg. Theatre or meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down 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 (add up total responses)				

Referring Doctor

Name:

Practice Number:

Contact Number:

Email:

Date:

Please email this referral to info@sleepbetter.co.za. Our staff will contact the patient to book a convenient appointment.