

REFERRAL FOR SCREENING ASSESSMENT OF SLEEP DISORDERED BREATHING

Mail To: Respiratory Nurse Specialists
Community Services
Grey Base Hospital
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PATIENT DETAILS (or affix label)

Name:

Address:.....

REFERRING PRACTITIONER

Referrer Name:

Practice Name & Address:

Date of Referral:

NHI:

D.O.B. / / Age: Gender: M/F

Telephone: Home: Work:

Tel:

Fax:

Referring Practitioner Signature:

SLEEP DISORDER FOR INVESTIGATION

Obstructive Sleep Apnoea Other (please state)

CLINICAL INFORMATION

ESS (see over page)

Weight kg Height cm

Neck Circumference cm

Occupation

Desaturation Index (if known)

Apnoea Hypoapnoea Index (if known).....

Other Medical Problems:

- Snoring most / every night
- Choking arousals / witnessed apnoeas
- Daytime hypersomnolence
- Sleepy when driving
- Psychiatric co-morbidity
- Cardiovascular co-morbidity

Clinical History:

Other Relevant Information:

Date received:

Received by:

Entered:

Date triaged:

Triage Category:

Patient type:

EPWORTH SLEEPINESS SCORE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

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

	Chance of Dozing (please circle)			
	0	1	2	3
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. theatre, meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes in the traffic	0	1	2	3

Total

/24