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| **SLEEP APNOEA REFERRAL FORM** | **salfcola 1** |

**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  |
| Surname |  | Forenames |  |
| Previous surname |  | Title |  | Gender |  |
| Date of birth |  |  |  |
| AddressPost Code |  | Home tel. no. |  |
| Work tel. no. |  |
| Mobile no. |  |

**Referral Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring clinician |  | Preferred clinician (if applicable) |  |
| GP Practice/ Department |  | New referral?  | [ ]  | Re-referral? | [ ]  |
| Date of referral |  | Date last seen |  |
| Date of consultation |  | Dates not available |  |

**Communication and Accessibility needs:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Interpreter required?: | Yes | [ ]  | No | [ ]  | Wheelchair access required?  | Yes | [ ]  | No | [ ]  |
| Language:  |  | Learning Disability:  |  |
| Hearing: |  | Other disability needing consideration:  |  |
| Vision: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | Military Service Person | [ ]  | Military Veteran | [ ]  | Member of Military Family |

|  |  |  |  |
| --- | --- | --- | --- |
| Smoking Status | [ ]  | Alcohol consumption |  units/week  |
| BMI |  | TFTs normal |  Yes [ ]  No [ ]  |
| Occupation |  | Referral for: Alcohol advice [ ] Smoking Cessation [ ]  Weight loss programme [ ]  |

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| Epworth Questionnaire Score (Measurement of propensity to fall asleep & is not a screening tool for tiredness) Epworth ≥ 10 (& symptoms) is suggestive of OSA [Epworth Sleepiness Questionnaire](http://www.icid.salisbury.nhs.uk/ClinicalManagement/Respiratory/Pages/EpworthSleepinessScale.aspx)Consider referral if patient has symptoms suggestive of OSA (see below) even if Epworth Score < 10Lower referral threshold for patients with COPD, or those who drive/operate heavy machinery for a living |  |
| Symptoms of Obstructive Sleep Apnoea (OSA) \*\* Dominant features |  |
| 1. Excessive daytime sleepiness \*\* | [ ]  |
| 2. Impaired concentration \*\* | [ ]  |
| 1. Persistent snoring \*\*
 | [ ]  |
| 1. Choking /obstructive episodes during sleep
 | [ ]  |
| 1. Witnessed apnoeas
 | [ ]  |
| 1. Regularly waking un-refreshed in the morning
 | [ ]  |
| 1. Restless sleep
 | [ ]  |
| 1. Irritability / Personality change
 | [ ]  |
| 1. Nocturia
 | [ ]  |
| 1. Decreased libido
 | [ ]  |

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| Primary Care patient management to date & any additional information (please refer to [Obstructive Sleep Apnoea guidance](http://app.mapofmedicine.com/mom/13/page.html?department-id=4&specialty-id=1015&pathway-id=3140&page-id=7539&history=clear)) : |

|  |
| --- |
| PMHx :  |
| Medication :  |
| Allergies :  |
| Blood Pressure |  | Latest HbA1c (if relevant) |  |
| Pulse |  | Home Support |  |

All new patient referrals must be made using this form.

Please refer by eRS.

It is very useful for us to have additional information from someone who lives with you. If you have a bed partner, they will be the best person to complete this form. If not, someone living in the same house as you would be able to complete some of the questions.

Please bring the completed form with you when you attend for your appointment in the sleep clinic.

**Questionnaire for bed partner / house-mate**

We are looking to see whether your partner has any trouble with their breathing while asleep, and it would be very helpful if you could answer the following questions:

QUESTION ANSWER

1. Does your partner snore loudly in their sleep? Yes [ ]  No [ ]

2. Is the snoring sufficiently loud to wake you at night? Yes [ ]  No [ ]

3. Has the noise been so bad that you have had to sleep in another room? Yes [ ]  No [ ]

4. Does your partner stop breathing during their sleep? Yes [ ]  No [ ]

5. Can you estimate how many times your partner stops breathing during the average night?

 1-10 [ ]

 2-20 [ ]

 >20 [ ]

6.. Have you ever felt the need to wake up your partner to see if they are alright? Yes [ ]  No [ ]

7. Is your partner restless in their sleep? Yes [ ]  No [ ]

8. Has your partner’s personality changed lately? Yes [ ]  No [ ]

8a. If so in what way----------------------------------------------------------------------------------------------------------------------------

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9. Does your partner fall asleep easily during the day? Yes [ ]  No [ ]

10. Has your partner ever fallen asleep when driving a car? Yes [ ]  No [ ]

11. Any other comments?------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------