

## SLEEP DISORDERED BREATHING REFERRAL FORM

<b>Name:</b>	<b>DOB:</b>	<b>Gender:</b>	
<b>Address:</b>	<b>Phone No:</b>		
	<b>NHI Number:</b>		
<b>Referring Doctor (&amp; contact address):</b>			
<b>Reason for Referral:</b>			
<b>Medications (including sedatives):</b>			
<b>Medical History</b>			
• Excessive daytime sleepiness	Y / N	• History of ischaemic heart disease	Y / N
• Loud snoring	Y / N	• Hypertension - mod/severe, poor control	Y / N
• Witnessed apnoea	Y / N	• Cardiac or Respiratory Failure	Y / N
• Road traffic/ other accident caused by drowsiness	Y / N	• History of cerebrovascular accident	Y / N
• Employment lost / threatened by symptoms:	Y / N	• Abnormal upper airway (tonsil, mandible, etc):	Y / N
<u>Specify:</u>		<u>Detail:</u>	
<u>Occupation:</u>			

### Other Medical History

**Weight:** \_\_\_\_\_ kg    **Height:** \_\_\_\_\_ m    **Body Mass Index** \_\_\_\_\_ kg/m<sup>2</sup>    **Neck circ** \_\_\_\_\_ cm

### Following questions to be completed by the PATIENT

<b>1. Which ethnic group do you belong to?</b> <span style="float: right;"><i>Tick the box or boxes which apply to you</i></span>				
a <input type="checkbox"/> Māori	b <input type="checkbox"/> Samoan	c <input type="checkbox"/> Niuean	d <input type="checkbox"/> Indian	
e <input type="checkbox"/> NZ European	f <input type="checkbox"/> Cook Island Māori	g <input type="checkbox"/> Tongan	h <input type="checkbox"/> Chinese	
k <input type="checkbox"/> other (such as Dutch, Japanese, Tokelauan). Please state.....				
<b>2. How often do you think you get enough sleep?</b> <span style="float: right;"><i>Please tick the box that applies to you</i></span>				
0 <input type="checkbox"/> Never	1 <input type="checkbox"/> Rarely	2 <input type="checkbox"/> Often	3 <input type="checkbox"/> Always	
<b>3. How often do you wake feeling refreshed?</b> <span style="float: right;"><i>Please tick the box that applies to you</i></span>				
0 <input type="checkbox"/> Never	1 <input type="checkbox"/> Rarely	2 <input type="checkbox"/> Often	3 <input type="checkbox"/> Always	
<b>4. How often do you snore?</b> <span style="float: right;"><i>Please tick the box that applies to you</i></span>				
0 <input type="checkbox"/> Never	1 <input type="checkbox"/> Rarely	2 <input type="checkbox"/> Often	3 <input type="checkbox"/> Always	
<b>5. How many hours sleep do you usually get in 24 hours?</b> <span style="float: right;">..... hours    .....minutes</span>				
<b>6. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?</b>				
This refers to your usual way of life in recent times. <span style="float: right;">PLEASE TICK ONE BOX ON EACH LINE</span>				
	<b>would never doze</b>	<b>slight chance</b>	<b>moderate chance</b>	<b>high chance</b>
Sitting and reading	..... 0 <input type="checkbox"/>	..... 1 <input type="checkbox"/>	..... 2 <input type="checkbox"/>	..... 3 <input type="checkbox"/>
Watching TV	..... 0 <input type="checkbox"/>	..... 1 <input type="checkbox"/>	..... 2 <input type="checkbox"/>	..... 3 <input type="checkbox"/>
Sitting inactive in a public place (eg. theatre, meeting)	..... 0 <input type="checkbox"/>	..... 1 <input type="checkbox"/>	..... 2 <input type="checkbox"/>	..... 3 <input type="checkbox"/>
As a passenger in a car for an hour without a break	..... 0 <input type="checkbox"/>	..... 1 <input type="checkbox"/>	..... 2 <input type="checkbox"/>	..... 3 <input type="checkbox"/>
Lying down in the afternoon when circumstances permit	..... 0 <input type="checkbox"/>	..... 1 <input type="checkbox"/>	..... 2 <input type="checkbox"/>	..... 3 <input type="checkbox"/>
Sitting and talking to someone	..... 0 <input type="checkbox"/>	..... 1 <input type="checkbox"/>	..... 2 <input type="checkbox"/>	..... 3 <input type="checkbox"/>
Sitting quietly after a lunch without alcohol	..... 0 <input type="checkbox"/>	..... 1 <input type="checkbox"/>	..... 2 <input type="checkbox"/>	..... 3 <input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	..... 0 <input type="checkbox"/>	..... 1 <input type="checkbox"/>	..... 2 <input type="checkbox"/>	..... 3 <input type="checkbox"/>

Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_