SLEEP MEDICINE CONSULTATION REQUEST FORM

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PATIENT DETAILS:

NAME: ....

DOB: ....

ADDRESS: ....

....

TEL: (H) .... (W)..........................

HEIGHT: ....WEIGHT:..................

CLINICAL DETAILS:

SNORING SEVERITY: ☐ mild ☐ moderate ☐ severe ☐ intermittent ☐ continuous

EPWORTH SLEEPINESS SCALE: Score each point 0 - 3
Chance of dozing (0 - unlikely, 1 - small chance, 2 - moderate chance, 3 - likely)

Watching TV:	☐	Sitting down after lunch	☐
Reading:	☐	Lying down after lunch	☐
Car passenger (1 hr)	☐	Seated and talking	☐
Stopped in traffic (10 mins)	☐	Attending meeting (movie)	☐
TOTAL:	/24	*(Normal < 10, mildy sleepy 10 - 12, moderately sleepy 13 - 15, extremely sleepy >15)*	

Observed apnoeas:	☐ occasionally	☐ weekly	☐ nightly	
Nasal Obstruction:	☐ nil	☐ mild	☐ moderate	☐ severe
Teeth:	☐ edentulous	☐ lower plate	☐ upper plate	☐ reasonable native teeth

ASSOCIATED CONDITIONS:

☐ Known cardiac disease ☐ Restless leg syndrome/ periodic leg movement in sleep

☐ Known cerebrovascular disease ☐ Insomnia ☐ Other sleep problems

OTHER CLINICAL INFORMATION: ....

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REFERRING DR. (Print name): ....

SIGNATURE: ....

DATE: ....PROVIDER NO: ....