**GP Referral to Adult Sleep Clinic Royal Free London NHS Trust**

**Patient Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **NHS Number** |  |
| **First Name** |  | **MRN (if available)** |  |
| **D.O.B** | Click here to enter a date. | **Date of referral** | Click here to enter a date. |
| **Address** |  |

**Screening questions: *(please answer yes or no to the following questions)***

|  |  |
| --- | --- |
| **Does the patient snore loudly?** | Choose an item. |
| **Does the patient feel tired or sleepy during the day?** | Choose an item. |
| **Has anyone observed the patient stop breathing during their sleep?** | Choose an item. |
| **Is the patient being treated for hypertension?** | Choose an item. |
| **BMI >35kg/m2?** | Choose an item. | **Actual BMI:** |
| **Age >50 years old?** | Choose an item. |
| **Neck circumference> 16 inches (40cm)?** | Choose an item. |
| **Male Gender?** | Choose an item. |

**Epworth Sleepiness Score:**

How likely is the patient likely to doze off or fall asleep in the following situations, in comparison to feeling just tired?

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

|  |  |
| --- | --- |
| **Situation** | **Chance of dozing (0=low, 3=high)** |
| *Sitting and reading* | Choose an item. |
| *Watching TV* | Choose an item. |
| *Sitting still in a public place (e.g. theatre, cinema or a meeting*  | Choose an item. |
| *As a passenger in a car for an hour without a break* | Choose an item. |
| *Lying down to rest in the afternoon when the circumstances allow* | Choose an item. |
| *Sitting and talking to someone* | Choose an item. |
| *Sitting quietly after lunch without having drunk alcohol* | Choose an item. |
| *In a car or bus while stopped for a few minutes in traffic* | Choose an item. |
| **TOTAL** | Choose an item. |

**Is the patient currently being investigated or treated for any of the following conditions?**

***(please answer yes or no)***

|  |  |
| --- | --- |
| **Ischaemic heart disease?** | Choose an item. |
| **Diabetes mellitus?** | Choose an item. |
| **Atrial fibrillation?** | Choose an item. |
| **Hypothyroidism?** | Choose an item. |
| **Cerebrovascular disease?** | Choose an item. |
| **Is the patient an occupational driver?** | Choose an item. |

Please attach a list of medication and current co-morbidities.

Thank you