**Referral to the Adult Sleep Service**

**Dr. Paddy Dennison Dr. Mark Jackson**

* **Referrals must be sent via the e-Referrals System (e-RS). Please attach this form, as well as any other relevant information/documents.**
* **Referrals will not be accepted unless this form is fully completed.**
* **For general advice (ONLY) prior to referral, email** [**adultsleepreferrals@uhs.nhs.uk**](mailto:adultsleepreferrals@uhs.nhs.uk)

**Referring and Triaging Criteria**

|  |  |
| --- | --- |
| **Do NOT Refer** | * Patient is experiencing snoring **ONLY**, i.e., with no symptoms suggestive of Sleep Apnoea. Consider recommending Mandibular Advancement Devices (MAD) and/or lifestyle changes instead, as per NICE guidelines. These patients should also not be referred to ENT, unless there is a primary nasal disorder during the day, which has not responded to primary care interventions. * Patient’ symptoms are suggestive of Insomnia **ONLY**, i.e., not explained by or associated with another (possible) sleep disorder. Consider sleep hygiene advice initially, and/or recommending digital platforms (e.g. Sleep Station, Sleepio…). Referring to a specialist centre for Insomnia requires a referral out of the region (e.g. London, Oxford), and thus other options should be explored prior to that. |
| **Routine** | Symptoms are interfering sufficiently with quality of life, affecting work, driving and social activities. Excessive sleepiness can be subjectively assessed using the Epworth Sleepiness Scale (attached): a score ≥ 10 is considered significant. The likelihood of Obstructive Sleep Apnoea can be evaluated using the STOP-BANG questionnaire (attached): a score ≥ 3 suggests that OSA may be present. |
| **Urgent** | We will aim to fast track the following requests:   * Individuals where maintenance of vigilance is of occupational or public health importance, particularly those who drive for a living and/or hold an HGV, PSV and Hackney Carriage licence; or in whom there has been suspicion of a driving accident related to sleepiness. * Individuals who are either pregnant or on a 2WW pre-operative pathway. |

**Patient details**

|  |  |
| --- | --- |
| **Patient Name:** |  |
| **Date of Birth:** |  |
| **NHS Number:** |  |

**Registered GP**

|  |  |
| --- | --- |
| **Name of Referring GP:** |  |
| **Date of Referral:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Do you consider this referral to be urgent? (see criteria in page 1)** | **Yes** |  |  | **No** |  |

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| **Reason for Referral:** |

Sleep-Disordered Breathing (Sleep Apnoea)

Narcolepsy/Idiopathic Hypersomnia (Hypersomnolence)

Sleep-Wake Rhythm Disorders (advanced/delayed sleep phase…)

Parasomnia (abnormal behaviours during sleep as sleepwalking, sleep-talking, dream enacting…)

Movement Disorders (Restless Leg Syndrome, Periodic leg movements…)

|  |
| --- |
| **Brief description of the case: (Including symptoms and main concerns)** |
| Click or tap here to enter text. |
| **Comorbidities:** |

**Hypertension**

**Diabetes**

**Heart Failure**

**Ischaemic Heart Disease**

**In-situ Pacemaker**

**Anxiety/Depression/other Mental Health Problems**

**Others:** Click or tap here to enter text.

**History of stroke or TIA**

**Atrial Fibrillation**

**COPD**

**Asthma**

**Respiratory Failure**

**Polycythaemia**

|  |
| --- |
| **Previous Sleep Investigations (if applicable):** |

Click or tap here to enter text.

|  |
| --- |
| **Current or Previous Sleep-Related Treatments (CPAP, MAD, prescribed drugs):** |

Click or tap here to enter text.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Does the patient drive?** | | **Yes** | |  | | **No** | |  | | | |
| **Does the patient hold an HGV/PSV driving licence?** | | **Yes** | |  | | **No** | |  | | | |
| **Is the patient an occupational driver?** | | **Yes** | |  | | **No** | |  | | | |
| **Has the patient (nearly) fallen asleep behind the wheel?** | | **Yes** | |  | | **No** | |  | | | |
| **Is the patient able to attend outpatient appointments?** | | **Yes** | |  | | **No** | |  | | | |
| **Does the patient require hospital transport?** | | **Yes** | |  | | **No** | |  | | | |
| **Is the patient on overnight oxygen therapy?** | | **Yes** | |  | | **No** | |  | | | |
| **Is the patient ambulant?** | | **Yes** | |  | | **No** | |  | | | |
| **Details**: | | | | | | | | | | |
|  |  | |  | |  | |  | |  |  | |
|  |  | |  | |  | |  | |  |  | |
| **Does the patient require an interpreter?** |  | | **Yes** | |  | | **No** | |  |  | |
| **If yes, what language**: | | | | | | | | | | |
|  |  | |  | |  | |  | |  |  | |
| **Does the patient have any infectious diseases?** |  | | **Yes** | |  | | **No** | |  |  | |
| **Details**: | | | | | | | | | | |

**Epworth Sleepiness Scale**

**Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_**

How likely are you are to doze off or fall asleep in the below situations?

Use the following scale to choose the most appropriate number for each situation:

|  |  |
| --- | --- |
| **Number** | **Meaning** |
| **0** | You would **NEVER** doze |
| **1** | **SLIGHT** chance of dozing |
| **2** | **MODERATE** chance of dozing |
| **3** | **HIGH** chance of dozing |

**Please note:**

* This scale is to assess your level of daytime sleepiness not tiredness.
* This refers to your usual way of life in recent times. Even if you haven’t done some of these things recently, try to imagine how they would have affected you.

|  |  |  |
| --- | --- | --- |
| **Situation** | **Chance of Dozing** | |
| Sitting and reading |  | |
| Watching TV |  | |
| Sitting, inactive in a public place (e.g. a theatre or a meeting) |  | |
| As a passenger in a car for an hour without a break |  | |
| Lying down to rest in the afternoon when circumstances permit |  | |
| Sitting and talking to someone |  | |
| Sitting quietly after a lunch without alcohol |  | |
| In a car, while stopped for a few minutes in the traffic |  | |
|  |  |  | |
| **Score** |  | |

**A score equal or greater than 10 suggests an excessive level of daytime sleepiness.**

**STOP-BANG Questionnaire**

**Screening Tool for Obstructive Sleep Apnoea**

**Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)? | Yes | No |
| Do you often feel **TIRED, fatigued, or sleepy** during daytime? | Yes | No |
| Has anyone **OBSERVED** you stop breathing during your sleep? | Yes | No |
| Do you have or are you being treated for high blood **PRESSURE**? | Yes | No |
|  | | |
| **BMI** greater than 35kg/m2?  Height (cm): \_\_\_\_\_\_\_\_\_ Weight (kg): \_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_\_ | Yes | No |
| **AGE** over 50 years old? | Yes | No |
| **NECK** circumference greater than 16 inches (40cm)? Size (cm): \_\_\_\_\_\_\_\_\_ | Yes | No |
| Is your **GENDER** male? | Yes | No |
|  |  |  |
| **Score** |  | |

**A score equal or greater than 3 is associated with increased likelihood of Obstructive Sleep Apnoea**