**HAMPSHIRE HOSPITALS**

***Please attach to the e-Referral***

**OBSTRUCTIVE SLEEP APNOEA REFERRAL FORM**

Patient name DOB NHS number

Patient address

|  |  |
| --- | --- |
| **Referral category** | **Please select** |
| Routine |  |
| Professional or HGV driver |  |

|  |  |
| --- | --- |
| **Epworth score** |  |

|  |  |
| --- | --- |
| **Conservative measures discussed/attempted:** | **Please select** |
| Weight reduction |  |
| Reduce/stop alcohol |  |
| Reduce/stop sedatives or sleeping tablets |  |
| Trial of mandibular advancement device |  |
| Thyroid function assessed and treated (including sub-clinical hypothyroidism) |  |

|  |
| --- |
| Additional information: |

**Accepted referrals:**

**Patients with an ESS of 10 or more AND with 2 or more of the following reported symptoms:**

|  |  |
| --- | --- |
| **Reported symptoms** | **Please select** |
| Excessive day time somnolence not explained by other factors (not fatigue) |  |
| Loud snoring |  |
| Witnessed apnoeas |  |
| Nocturnal choking/gasping |  |
| Involved in a road traffic accident related to falling asleep * or nodding off at the wheel
 |  |

***Incomplete referrals will be returned without an appointment***