	**SLEEP STUDY REFERRAL QUESTIONNAIRE**

Surname_____ **First Name**_____

DOB _____ **Sex** _____ **NHI**_____

(Please circle)

Daytime sleepiness	Yes	No
Snoring	Yes	No
Witnessed Apnoeas	Yes	No
Truck/ Bus Driver	Yes	No

Height (Metres)_____ **Weight (Kg)**_____ **BMI**_____

Neck circumference (cm) _____

Epworth Sleepiness Score _____

(Please circle)

Approximate Sleep latency	@ 2min	@10 min	@ 30min	60min +
Typical nights sleep	<5hrs	<7hr	>7hrs	
Taking sedation/ Alcohol to aid sleep	Yes	No		
Suffers from insomnia	Yes	No		
Chronic pain disturbing sleep	Yes	No		
Chronic nasal congestion	Yes	No		