York Sleep and Ventilation Service Sleep Assessment

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Part 1- Patient to complete

Please fill in as much information as you can on pages 1, 2, 3 and 4. **Please bring this with you to your sleep assessment appointment.** During the assessment with the sleep team assessor they will help with any questions that you are unsure about. If you need help at any time, please ask a member of the sleep team.

Patient Details NHS number:

Name: ……………………….………..……………………….………………..........

Address: …………………………………………………………………………

Telephone Number: ……….…………………………………………………

Date of Birth: ……………………………….. Age:……………………………

Type of sleep problem: What is the reason for this appointment?

Investigation for possible:
☐ Obstructive Sleep Apnoea (snoring and breathing pauses overnight)
☐ Excessive daytime sleepiness

Other medical problems

☐ High blood pressure
☐ Heart Disease including heart attack/abnormal heart rhythm including atrial fibrillation (AF)
☐ Stroke/mini stroke (TIA)
☐ Diabetes
☐ Mental Health including depression or anxiety
☐ Operations on your nose, jaw or face e.g. tonsils/adenoids/sinuses
☐ Other- please give details

…………………………………………………………………………

…………………………………………………………………………

Medications – also include any over the counter medications

Please write them here or give a full list to the sleep assessor at your appointment

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……………………………………………………………………

Medication allergies including latex/plasters

……………………………………………………………………

Sleep history

Do you snore? Yes ☐ No ☐

Has anyone witnessed that you stop breathing or go quiet during sleep? Yes ☐ No ☐

Do you wake with a choking sensation? Yes ☐ No ☐

Does anyone in your family have sleep apnoea? Yes ☐ No ☐

Do you wake up most mornings with a headache? Yes ☐ No ☐

What time do you normally go to sleep? …………………………………….

What time do you normally wake up? …………………………………….

How long does it take you to go to sleep? …………….…………………….

Do you wake during the night? Yes ☐ No ☐

Do you wake to go to the toilet? Yes ☐ No ☐

If Yes, how many times? …………………………….

Do you often feel fatigued, tired, or sleepy during the daytime? Yes ☐ No ☐

Do you wake feeling refreshed? Yes ☐ No ☐

Do you usually nap during the day? Yes ☐ No ☐

If Yes, how many times and how long for? ………………………………

Social Considerations

Average Daily Alcohol Intake:

☐ None ☐ 1 drink ☐ 2+ drinks   Details: ……………………………………….

Average Daily Caffeine Intake (tea, coffee, energy drinks etc):

☐None ☐1–3 cups ☐4–6 cups ☐7+ cups Time of day of last drink …………

Smoking Status: Non-smoker ☐   Smoker ☐   Previous smoker ☐

Work/Occupation

What is your usual job? ……………………………………….

Are you retired or on a benefit? Yes ☐ No ☐

Do you do shift work? Yes ☐ No ☐

If yes, please give further information (please describe your shift pattern):

……………………………………………………………………………
……………………………………………………………………………

Driving

Do you have a current driver's licence? Yes ☐ No ☐

If yes do you hold an HGV/PSV or other commercial license? Yes ☐ No ☐

Have you ever felt sleepy while driving? Yes ☐ No ☐

Have you ever had a sleep related road incident or accident? Yes ☐ No ☐

Do you drive as part of your occupation? Yes ☐ No ☐

Do you operate heavy machinery or have a safety critical role/job?
Yes ☐ No ☐

Please confirm that you have received advice regarding the DVLA guidelines including advice that you must not drive if feeling sleepy- see enclosed "Driving and Sleep apnoea Leaflet": Yes ☐

Restless Legs

Do you have any pain that disturbs your sleep? Yes ☐ No ☐

Do you get "restless legs" Yes ☐ No ☐

If you have answered yes, please complete answer the following:
When you sit or lie down do you have a strong desire to move your legs?
Yes ☐ No ☐ Don't Know ☐

Does your desire to move your legs feel impossible to resist?
Yes ☐ No ☐ Don't Know ☐

Could you describe the sensation as (circle):
unpleasant / creepy crawly / itching / pulling / bumping / tugging?

Does moving your legs make them feel better?
Yes ☐ No ☐ Don't Know ☐

Are these symptoms worse at night? Yes ☐ No ☐ Don't Know ☐

Does your partner ever report you have twitching legs at night?
Yes ☐ No ☐ Don't Know ☐

Have you ever had any "abnormal" night-time behaviour? (e.g., sleep walking, sleep talking, abnormal movements, nightmares or acting out your dreams)
Yes ☐ No ☐ Don't Know ☐

Do you have any other information that may help the sleep assessment that has not already been asked or any questions/concerns? If so, please write them here:

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…………………………………………………………………
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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling tired?
This refers to your usual way of life in recent times.
Even if you haven't done some of these things recently please try to work out how they would have affected you.
Please answer the last question as if you were a driver if you drive and as a passenger if you are a non-driver.

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**
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 or bus, while stopped for a few minutes in the traffic	☐
Total	☐

This is the end of this section; the next pages will be completed by your assessor at your assessment.

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Part 2- Assessor to complete at appointment

PATIENT DETAILS

Name: Date of Birth:

NHS number: Case note number:

EXAMINATION to be completed by sleep specialist team member

Height (cm) ☐ Weight (kg) ☐ Collar (In) ☐ BMI ☐

Do you wear dentures? Yes ☐ No ☐

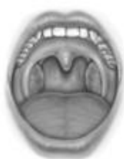
Retrognathia? Yes ☐ No ☐

Nasal patency: (ask patient to block each nostril and “sniff”)

Left good Yes ☐ No ☐

Right: good? Yes ☐ No ☐

Friedman Palate Classification (circle most applicable)



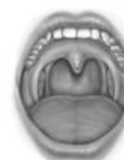
I
Allows visualisation of the entire uvula and tonsils/pillars

II
Allows visualisation of the uvula but not the tonsils

III
Allows visualisation of the soft palate but not the uvula

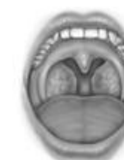
IV
Allows visualisation of the hard palate only

Friedman tonsils (circle most applicable)



Size 0 - 1
Tonsils, site 1, are hidden within the pillars

Size 2
Tonsils, site 2, extend to the pillars



Size 3
Tonsils, site 3, extend beyond the pillars but not to the midline

Size 4
Tonsils, site 4, extend to the midline

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Patient name:

NHS No:

D.O.B:

Pathway Clinic Date:

MDT Date:

MDT DISCUSSION AND OUTCOME:

Request for repeat or higher level study

☐ Failed or technically inadequate study

☐ Diagnosis indeterminate

☐ Investigation for RLS

CPAP/ASV/NIV treatment trial

☐ Placed on CPAP waiting list   Routine / Urgent

☐ Placed on ASV waiting list   Routine / Urgent

☐ Placed on NIV waiting list   Routine / Urgent

ENT referral

☐ Evidence of upper airway issues

MAD referral

☐ Dental letters sent

COMPLEX case

☐ List for physician clinic review

Discharge ☐

OTHER please specify

…………………………………………………………………………………………………

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