DR KOBUS VAN DER WALT
Specialist General Psychiatrist

REQUEST FOR SLEEP INVESTIGATION / MANAGEMENT

Patient Details:			
Patient Name & Surname:		ID Number:	
Contact number:		Email:	

Medical Aid information:			
Medical Aid Name:		Number:	
Plan:		Dependant code:	
Main Member:		Main Member ID:	

PMB status				
Is this request related to the management of a PMB condition?		Yes		No

	Arrythmia		Depression
	Type II Diabetes Mellitus		Cerebrovascular disease
	Cardiovascular disease		Hypertension
Other:			

Services Required:	
	Overnight home-based Polysomnogram
	CPAP titration
Report to be sent to:	

Scores (see attached documents for completion):					
STOPBANG Score:		/ 8	Epworth Sleepiness Score:		/24

Referral Doctor:			
Name and Surname:		Practice Number:	
Email:		Date requested:	
Signature:			

t. +27 (0)21 852 8836 | f. +27 (0)86 580 5699
e. reception@drkobusvanderwalt.co.za
a. Unit 105, Halo Medical Suites,
31 Gardiner Williams Avenue, Somerset West, 7130.

Sarel J Van Der Walt Inc
MB ChB, MPhil (Applied Bioethics), MMed (Psychiatry), FC Psych (SA)
Practice number: 0920797 | HPCSA: MP0643823 | Reg No: 2020/714896/21

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STOPBANG	Y	N
Snoring?		
Do you Snore Loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?		
Tired?		
Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving or talking to someone)?		
Observed?		
Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep?		
Pressure?		
Do you have or are being treated for High Blood Pressure?		
Body Mass Index more than 35 kg/m^2?		
Age older than 50?		
Neck size large? (Measured around Adams apple)		
Is your shirt collar 16 inches / 40cm or larger?		
Gender = Male?		

Body Mass Index Calculator:	cm / kg:		Height:		Weight:		BMI:	

Total:		/8

Epworth Sleepiness Scale

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.
Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.
Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting, inactive (e.g., in a public place – meeting, theatre or dinner)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

Total:		/24

Once completed, please submit this form to nursing@drkobusvanderwalt.co.za

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