QUEEN ELIZABETH HOSPITAL

# SLEEP STUDY REQUEST

HQE/KP/MED/016

U.R.N :

SURNAME:
FIRSTNAME:
DOB:

OVERNIGHT ANALYSIS REQUIRED : ☐

RESPIRATORY SLEEP DISORDERS CLINIC
DEPARTMENT OF RESPIRATORY MEDICINE
QUEEN ELIZABETH HOSPITAL

DATE OF STUDY:

TYPE OF STUDY:

☐ **COMPREHENSIVE:**

| | **SIMPLE** | ***COMPLEX** |
|---|---|---|
| **FLOW** | ☐ | ☐ |
| **PRESSURE** | ☐ | ☐ |
| **SPLIT** (flow/Pressure) | | ☐ |

*COMPLEX includes

☐ VPAP/BIPAP
☐ ptcCO2 ☐ $CO_2$ in vivo cal
ABG……mmHg
☐ PetCO2
☐ 45 mm Hg
☐ $O_2$
☐ Inpatient (Ward……………………)

☐ Disabled/mobility problem
☐ Morbid obesity ( BMI ≥ 50)

☐ Oesophageal pressure/pH

☐ **MSLT**

☐ **DOMESTIC** : ☐ Flow ☐ CPAP

**TREATMENT:**

☐ CPAP:….cm H2O min……cm H2O max…..cm H2O

☐ NIV: IPAP….cm H2O EPAP…….cm H2O
Rate:…../min Ti/T tot..**MODE**….

☐ MAS ☐ Split study

☐ FiO2…….1/min ☐ nasal prongs or mask ☐

**MEDICATIONS:**

☐ Temazepam 10-20 mg prn ☐ Nil sedation

☐ Imovane 7.5 – 15 mg prn

Other:…………………………………………………………………………….

……………………………………………………………………Signature

Note: Sedatives must be prescribed by the doctor and noted by the technologist stating time in log.

**OTHER:**

☐ Holter Monitor ☐ TDA

☐ Morning ABGs

**SPECIAL CARE:**

☐ Nursing/Carer
☐ Lifting/Dressing

☐ Special mattress
☐ Hoist

**CLINICAL DETAILS/NOTES:**……………………………………………………………….

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| **Technologist Initials** | | **Medications Initial Time** | | |
|---|---|---|---|---|
| Calibration………………………… | ☐ | Temazepam…………… | | ……… |
| Set-up ½…………………/……………… | ☐ | Imovane | …………… | ……… |
| Set-up ¾ ……………./ ……………. | | | | |
| | | Other………………………………………… | | |
| Monitor ½ …………/ ………… | | | | |
| | | ……………………………………………… | | |

| **Date of request:** | **Dr's Signature:** | **Addess:** |
|---|---|---|

| **Other Investigations:** | **Date** | **Time** |
|---|---|---|
| ☐ Ventilatory function | ……………………… | ……………… |
| ☐ Routine Assessment | ………………………… | ……………… |
| ☐ Nasal Resistance | ………………………… | ……………… |

☐ Other (specify in handwriting of requesting Dr)………………………………………