Dr Robyn O'Sullivan FRACP
Provider No 0123054H

Dr Allan Finnimore FRACP
Provider No 957565K

SLEEP STUDY REFERRAL FORM

SLEEP CARE - www.sleepcare.com.au - 1300 75 33 75
Tel: 07 3397 3036 Fax: 07 3397 3013 Email: admin@sleepcare.com.au

PATIENT DETAILS/HOSPITAL ID STICKER

Name ______________________________

Address ______________________________

____

Telephone ______________________

Date of birth ______________________

❒ **Sleep Physician Consultation** **Commercial Driver** ❒ Yes ❒ No

STUDY TYPE REQUESTED

Diagnostic Sleep Study ❒ in-lab (Rationale: ______________________) ❒ Level 2 Home Study

Treatment Study
(a Sleep Physician consult is necessary)

❒ CPAP titration ❒ CPAP check ❒ MAS study
❒ NIV ❒ ASV ❒ MSLT ❒ MWT ❒ 10-20 EEG ❒ Video
❒ Waking ABG ❒ Transcut CO_2 ❒ O_2 at ___L/min

Co-Morbidities

❒ Hypertension ❒ Atrial fibrillation ❒ Heart failure
❒ Ischaemic heart disease ❒ Suspected central apnoea ❒ CVA ❒ Epilepsy
❒ Chronic pain on narcotics ❒ Sleep-related movements ❒ Suspected parasomnia ❒ COPD
❒ Diabetes ❒ Depression

INDICATIONS FOR SLEEP STUDY

EPWORTH SLEEPINESS SCORE

	Would never doze (0)	Slight chance of dozing (1)	Moderate chance of dozing (2)	High chance of dozing (3)
Sitting and reading	❒	❒	❒	❒
Watching TV	❒	❒	❒	❒
Sitting inactive in a public place (eg cinema or meeting)	❒	❒	❒	❒
Being in a car for an hour as a passenger (without a break)	❒	❒	❒	❒
Lying down to rest in the afternoon (when possible)	❒	❒	❒	❒
Sitting and chatting to someone	❒	❒	❒	❒
Sitting quietly after lunch (not having had alcohol)	❒	❒	❒	❒
In a car when you stop in traffic for a few minutes	❒	❒	❒	❒

Total ________

OSA 50 QUESTIONNAIRE

	If "yes" circle
Is waist circumference >102cm if male or >88cm if female?	3
Has the patient's snoring ever bothered other people?	3
Has anyone reported apnoeas during the patient's sleep?	2
Is the patient over 50 years of age?	2

Total ________

Please note: Epworth Sleepiness Score must be ≥8 and OSA50 Score must be ≥5 to meet criteria for Medicare funding. If these criteria are not met, please request a Sleep Physician Consult.

SYMPTOMS

❒ Snoring ❒ Wakes choking ❒ Witnessed apnoeas ❒ Nocturia
❒ Restless legs ❒ Drowsy driving ❒ Memory problems ❒ Morning headache

MEDICATION LIST - attach list if insufficient space

REFERRING DOCTOR

Name ______________________________ Date ______________

Address ______________________________ Provider No. ______________

Signature ______________________ Copy to ______________________

❒ Greenslopes Private Hospital ❒ Sunnybank Private Hospital ❒ St Andrews Place Sleep Centre ❒ Mater Private Redlands