

## Sleep Test Referral

### Patient Details

Name ..... DOB .....

Mobile / Phone ..... Email .....

Address .....

### Clinical History

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Insomnia                     | <input type="checkbox"/> Restless Legs           | <input type="checkbox"/> Cardiac History     |
| <input type="checkbox"/> Snoring                      | <input type="checkbox"/> Sexual Disinterest      | <input type="checkbox"/> CVA / Stroke        |
| <input type="checkbox"/> Nocturnal Gasping/Choking    | <input type="checkbox"/> Bruxism/TMJ Pain        | <input type="checkbox"/> Hypertension        |
| <input type="checkbox"/> Witness apneas               | <input type="checkbox"/> Anxiety/Depression/PTSD | <input type="checkbox"/> Nocturia            |
| <input type="checkbox"/> Unrefreshed Sleep            | <input type="checkbox"/> Concentration Issues    | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Daytime Lethargy/Sleepiness  | <input type="checkbox"/> Commercial Driver       | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Clinical Notes / Extra Info: |  |  |

### Sleep Services

#### Home Sleep Test

##### Medicare Funded - Sleep Test

(Requirements Apply - see overleaf)

- ☐ Meets Medicare Criteria; or  
☐ Referred by Respiratory/Sleep Physician

##### Private Fee - Sleep Test

- ☐ Private Fee | DVA | Work Cover

#### Services

- ☐ Sleep Physician Consult (Telehealth)  
☐ CPAP Initiation / Review

### Referring Doctor

Doctor Name ..... Provider # .....

Phone ..... Email .....

Practice Name .....

Doctor Signature ..... Date of Referral .....

*Please email to **sleep@athomesleeptest.com.au** or fax **(02) 9188 8938***

The Medicare rebate is valid if no prior study has been undertaken in the previous 12 months and aged 18 years and over.

Referring Doctors can have sleep test results sent directly back to them to facilitate treatment management, without a Sleep / Respiratory Physician consult if the patient meets the following Medicare criteria.

Alternatively, if the patient falls short of meeting the Medicare criteria, then a Full Sleep Investigation service will be required which includes a Sleep / Respiratory Physician consult for the patient to obtain their Sleep Test Results.

## Express Sleep Test Criteria requirements

Epworth Sleepiness Score  $\geq 8$  ☐

### AND one of the following:

☐ OSA50  $\geq 5$ , **OR**

☐ STOP-BANG  $\geq 3$ , **OR**

☐ BERLIN QU. (tick if positive)

## Epworth Sleepiness Questionnaire

How likely are you to dose off or fall asleep in the following situations, in contrast to sitting and reading just feeling tired? This refers to your recent / current way of life. Even if you have not done some of these things recently, try to determine how they would affect you.

<i>Circle the response that best describes:</i>	Never	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car as a driver stopped for a few minutes in traffic	0	1	2	3
ESS Total _____ (Min 8 required)				

## STOP-BANG / OSA 50

	STOP-BANG	OSA50
Feel tired, fatigued, or sleepy during the daytime?	1	-
Do you have (or are you being treated for) high blood pressure?	1	-
BMI > 35 kg/m <sup>2</sup>	1	-
Neck circumference > 40 cm	1	-
Gender Male?	1	-
Has your snoring ever bothered other people?	1	3
Anyone observed you stop breathing or choking/gasping during sleep?	1	2
Aged 50 years or over?	1	2
Waist circumference (male > 102cm, female > 88cm)	-	3
<b>TOTAL</b>		
<b>Minimum of either required</b>	3	5

**For the Berlin Questionnaire visit**

**[www.athomesleeptest.com.au/berlinquestionnaire](http://www.athomesleeptest.com.au/berlinquestionnaire)**