SLEEP REFERRAL FORM

Sleep Connect
Connecting you to better sleep

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General Medicine, Respiratory & Sleep Physician
LOCATIONS: REDCLIFFE & CABOOLTURE

PATIENT DETAILS

Name:_____ **DOB:**_____ **Phone:** _____
Email:_____ **Medicare / DVA no:**_____ **Ref:**_____ **Exp:**___
Commercial Licence: ☐ Y ☐ N

MEDICAL HISTORY

Height:____m **Weight:**____kg **Previous Sleep Study:** Y☐ N☐ **Date of Study:**_____ **Established on CPAP:** Y☐ N☐

SYMPTOMS/MEDICAL CONDITIONS: *(Please tick)*

☐ Snoring ☐ Witnessed Apnoeas ☐ Nocturnal Gasping/Choking ☐ Pacemaker ☐ Waking Unrefreshed
☐ Morning headaches ☐ Daytime Somnolence ☐ Neurocognitive Impairment ☐ Nocturia ☐ Cardiovascular Disease

Other Relevant Medical Conditions:_____ *Please attach Patient's Medical History & Medication list*

REQUEST FOR A REFERRAL

(please mark appropriate options)

- ○ **Home Sleep Study** – This covers a Home Sleep Study, and if required, sleep physician consultation and CPAP therapy
- ○ **CPAP/APAP** trial for the treatment of Sleep Apnoea
- ○ **CPAP therapy review** (pressure, compliance, mask review & full equipment check)
- ○ **Supply of DVA approved equipment and services**

MEDICARE ELIGIBILITY

***To be eligible for a Medicare Bulk Billed Sleep Study, you must score:**

Equal to or more than **3** on **STOP-BANG** AND Equal to or more than **8** on **EPWORTH SLEEPINESS SCALE (ESS)**

MEDICARE REQUIRES BOTH QUESTIONNAIRES TO BE COMPLETED

EPWORTH SLEEPINESS SCALE – *Patient must score 8 or more*

How likely are you to doze off (fall asleep) in the following situations?

Sitting and reading	○ 0	○ 1	○ 2	○ 3
Watching television	○ 0	○ 1	○ 2	○ 3
Sitting inactive in a public place	○ 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
As a passenger in a car for an hour without a break	○ 0	○ 1	○ 2	○ 3
In a car, while stopped for a few minutes in traffic	○ 0	○ 1	○ 2	○ 3

Use the following scale to choose the most appropriate answer:

0 – No chance
1 – Slight chance
2 – Moderate chance
3 – High chance

TOTAL SCORE *(≤ 8):

/24

+

STOPBANG – *Patient must score 3 or more*

Does the patient **Snore** loudly? (loud enough to be heard through closed doors)	○ Yes	○ No
Do they often feel **Tired**, fatigued, or sleepy during the day?	○ Yes	○ No
Has anyone **Observed** them stop breathing or choking/gasping during their sleep?	○ Yes	○ No
Do they have or are they being treated for High Blood **Pressure**?	○ Yes	○ No
Is their **BMI** (Body Mass Index) greater than 35?	○ Yes	○ No
Are they **Aged** 50 years and older?	○ Yes	○ No
Is their **Neck** circumference greater than 40cm?	○ Yes	○ No
Is their **Gender** Male?	○ Yes	○ No

TOTAL SCORE *(≤ 3):

/8

FOR THIS REFERRAL TO BE VALID, PLEASE ENSURE THE FOLLOWING DETAILS ARE COMPLETED

Referring Dr.:_____ Practice Name:_____
Provider No:_____ Phone: _____
Signature:_____ Email: _____