Home Sleep Study Referral Form

(Level 1 above TAB)
2/31-33 Horton St
Port Macquarie NSW 2444
admin@sleepapnoeaclinic.com.au
0408 855 734

Patient Surname: ______________________________ **DOB:** __________________________________

First Name: __________________________________ **Phone:** ___________________________________

Medicare No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **(valid to)** _____ / ________

Height: _________cm **Weight:** _________ kg **BMI:** ____________

Referral MUST be completed and SIGNED by the Referring Physician

Doctor Name: ________________________________ Stamp:

Provider #: _________________________________

Signature: __________________________________

Phone:______________________________________ Email:____________________________________

SYMPTOMS ☐ **Snoring** ☐ **Witnessed apnoea** ☐ **Gasping in sleep** ☐ **Excessive Daytime Sleepiness**

☐ **Indication for Home Sleep Study = OSA** Item 12250 for patients aged 18 years or more who require a diagnostic sleep study. Direct GP referral to testing without personal assessment by a sleep or respiratory physician, when validated screening questionnaires suggest a high pre-test probability for diagnosis of symptomatic, moderate-severe obstructive sleep apnoea (OSA).

In accordance with the Australasian Sleep Association's Guidelines for Sleep Studies in Adults, relative contraindications for an unattended sleep study to investigate suspected OSA include but are not limited to:

YES	NO	If yes is answered to any of the following please contact us to discuss the referral in more detail
☐	☐	(a) intellectual disability or cognitive impairment
☐	☐	(b) physical disability with inadequate carer attendance
☐	☐	(c) significant co-morbid conditions including neuromuscular disease, heart failure or advanced respiratory disease where more complex disorders are likely
☐	☐	(d) suspected respiratory failure where attended measurements are required, including measurement of carbon dioxide partial pressures
☐	☐	(e) suspected parasomnia or seizure disorder
☐	☐	(f) suspected condition where recording of body position is considered to be essential
☐	☐	(g) previously failed or inconclusive unattended sleep study
☐	☐	(h) unsuitable home environment including unsafe environments or where patients are homeless
☐	☐	(i) consumer preference based on high level of anxiety about location of study or where there is unreasonable cost or disruption based on distance to be travelled, or home circumstances.

Please complete questionnaires on page 2 to ensure study meets eligibility criteria

Medical History **Please tick where relevant**

☐ Hypertension ☐ Ischaemic Heart Disease ☐ Type 2 Diabetes ☐ Obesity

☐ Cardiac Failure ☐ Asthma ☐ Family History (OSA)

☐ Atrial Fibrillation ☐ COPD ☐ Other ____

Has the patient had a Home Sleep Study in the past 12 months Yes / No (if yes, please call to discuss eligibility)

ESS and STOP BANG scores MUST be complete to meet Medicare criteria

ESS- Epworth Sleepiness Scale

Must score 8 or more to qualify **Total Score _____ /24**

How likely are you to doze or fall asleep in the following situations, in contrast to just feeling tired?

0= Never 1= Slight chance 2= Moderate 3=High chance

Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place (movies/meeting)	☐ 0	☐ 1	☐ 2	☐ 3
Passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon	☐ 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, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3

STOP BANG Questionnaire

Must score 3 or more to qualify **Total Score ______ /8**

1 point for each YES response	**YES**	**NO**
Snoring- do you snore loudly?	☐	☐
Tired- are you tired, fatigued or sleepy during the daytime?	☐	☐
Observed apnoea- stop breathing, choke or gasp during your sleep?	☐	☐
Pressure- do you have or are you being treated for high blood pressure?	☐	☐
BMI- greater than 35?	☐	☐
Age- over 50?	☐	☐
Neck circumference- greater than 40cm?	☐	☐
Gender- Male?	☐	☐

Referral approved for home sleep study (item number 12250) Yes/No
By Dr R KILLICK (Sleep Physician): ___________________ Date: _____________