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 ❏ ❏ Unsuitable for Unattended Sleep Study ❏ Level 2 Home Study

In-lab study requested by patient ❏ Reason _____

SIGNIFICANT CO-MORBIDITIES

❏ Hypertension ❏ Atrial fibrillation or Arrhythmia ❏ Heart failure
❏ Ischaemic heart disease ❏ Suspected central apnoea ❏ Neurological disease ❏ Epilepsy
❏ Chronic pain on narcotics ❏ Sleep-related movements ❏ Suspected parasomnia ❏ COPD

Treatment Study
(a Sleep Physician consult is necessary)

❏ CPAP titration ❏ CPAP check ❏ MAS study
❏ NIV ❏ ASV ❏ MSLT ❏ MWT ❏ 10-20 EEG ❏ Video

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)	
Seating 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