REFERRAL FORM

SleepingTest
Good Health Starts With Sleep

Please send your referral to us by Email: sleep@savingbrothers.com

PATIENT DETAILS

Patient name _____ D.O.B ____ / ____ / _____

Address _____ Phone _____

Email Address _____

SLEEP TEST TYPE *(Please mark appropriate circle/s)*

- ○ Ambultatory PSG Home Sleep Test (Level 2 Medicare approved and private pay available)
- ○ OSA Screen (Level 3 private pay option, collect from clinic)
- ○ OSA Screen (Express Test posted to patient, private pay)

Each sleep test type is reviewed and reported on by a Sleep & Respiratory Physician

ESS Questionnaire

For a Medicare subsidised sleep study a patient must score 8 or more on the following.

How likely are you to doze off in the following situations?

Sitting and reading	○ 0	○ 1	○ 2	○ 3
Watching television	○ 0	○ 1	○ 2	○ 3
Sitting inactive, in a public space	○ 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 a 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 ESS Score *(out of 24)*

STOP BANG Questionnaire

For a Medicare subsidised sleep study a patient must score 5 or more. Each question is worth 1 point

YES = 1 / NO = 0

Do you **S**nore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?		
Do you often feel **T**ired, fatigued, or sleepy during the day (such as falling asleep during driving or talking to someone)?	○ Yes	○ No
Has anyone **O**bserved you stop breathing or choking/gasping during your sleep?	○ Yes	○ No
Do you have or are you being treated for high blood **P**ressure?	○ Yes	○ No
Is your **B**ody mass index more than 35 kg/m2?	○ Yes	○ No
Are you **A**ged older than 50?	○ Yes	○ No
Is your **N**eck size large: For male, is your shirt collar 17 inches / 43cm or larger? For female, is your shirt collar 16 inches / 41cm or larger? (Measured around adams apple)	○ Yes	○ No
Is your **G**ender male?	○ Yes	○ No

TOTAL SCORE ***(out of 8)***

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Reason for Sleep Test Referral (Please tick)

- ☐ Snoring
- ☐ Choking/gasping
- ☐ Lethargy/fatigue
- ☐ Nocturia (waking to urinate)
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Restless sleep
- ☐ Weight gain
- ☐ Other *(Please specify)*
- ☐ Witness apneas
- ☐ Daytime sleepiness
- ☐ Waking with morning headaches
- ☐ Anxiety
- ☐ Irritabiliity
- ☐ Short-term memory loss
- ☐ Sleepy driving
- ☐ Erectile dysfunction

Medical Conditions

- ☐ Hypertension
- ☐ Heart failure
- ☐ Stroke
- ☐ Depression
- ☐ Other *(Please specify)*
- ☐ Atrial fibrillation
- ☐ Coronary artery disease
- ☐ Type II diabetes
- ☐ Sleep Apnea or Family history of sleep apnea

Eligibility criteria for Medicare subsided home sleep test 12250

Epworth Sleepiness Scale (ESS) - score of 8+
Stop Bang - score of 5+
1 x MBS item code 12250 for home sleep test claimed in the last 12month
Aged: 18years +

Referring Doctor Detials

Referring Doctor Name:_____

Provider Number:_____

Practitce Name:_____

Address: _____

Email:_____

Phone:_____

Referral date:_____

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