MID NORTH COAST **SLEEP CLINIC**

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HOME SLEEP STUDY REFERRAL FORM

TO: ASSOCIATE PROFESSOR MICHAEL DODD,

PATIENT DETAILS

Name: ..... DOB: .....

Telephone 1: ..... Telephone 2: .....

Email: .....

MEDICAL HISTORY: Hypertension ☐ Type 2 Diabetes ☐ Atrial Fibrillation ☐ Cardiac Failure ☐

Asthma ☐ Obesity ☐ COPD ☐ Other Co-Morbidities: .....

.....

SERVICE REQUIRED: HOME SLEEP STUDY: IN CLINIC SETUP ☐ SETUP IN PATIENT'S HOME ☐

Patient must meet **both of the below criteria to qualify for a Home Sleep Study**

EPWORTH SLEEPINESS SCALE

How likely are you to fall asleep in the following situations?

Please score each activity using the following guide:
0 = would never doze **1** = slight chance of dozing
2 = moderate chance **3** = high chance of dozing

ACTIVITY	SCORE
Sitting and reading	.....
Watching television	.....
Sitting, inactive in a public place (theatre/meeting)	.....
As a passenger in a car for an hour with no break	.....
Lying down to rest in the afternoon, if able	.....
Sitting and talking to someone	.....
Sitting quietly after lunch without alcohol	.....
In a car while stopped for a few minutes in traffic	.....

TOTAL SCORE ..... /24

To qualify for a Home Sleep Study the patient should score: ≥ 8/24

STOP BANG QUESTIONNAIRE

Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? **YES / NO**

Tired: Do you often feel tired, fatigued or sleepy during daytime? **YES/ NO**

Observed: Has anyone observe you stopping breathing during your sleep? **YES / NO**

Blood pressure: Do you have or are you being treated for high blood pressure? **YES / NO**

BMI: Is your BMI more than 35kg/m2? **YES / NO**

Age: Are you over 50 years old? **YES / NO**

Neck Circumference: Is your neck circumference greater than 40cm/15¾"? **YES / NO**

Gender: MALE ☐ FEMALE ☐

To qualify for a Home Sleep Study patient should answer YES to 4 or more questions.

All Medicare subsidised studies must meet the approved criteria above, in accordance with Medicare item 12250. The assessment and appropriateness of home studies are overseen by a supervising sleep physician.

OTHER SERVICES REQUIRED:

- **CPAP/APAP TRIAL:** Therapy trial ☐
- **CPAP Therapy Pressure Review** with Oximetry ☐
- **Supply of DVA equipment and services** ☐

REFERRING DOCTOR'S DETAILS

NAME ..... PROVIDER NUMBER .....

ADDRESS.....

SIGNATURE ..... DATE:.....

PLEASE FAX THIS REFERRAL 65510700. Our Staff will contact the patient to book a convenient appointment.

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