Home Sleep Test Referral

TO BOOK SLEEP STUDY **you need a GP referral first** and contact any of the following.

Rosebud CPAP: Phone 59867136, email: rosebudcpap@outlook.com

CPAP Network Mornington: Phone 59905888, email: mornington@cpapnetwork.com.au

Alternately you can ask your GP to book a study closer to you.

AFTER YOU GET YOUR SLEEP STUDY to book you clinic

Surgical patients or for those considering surgery: CSSC 97893636

Non-Surgical Patients, pl contact Peninsula Sleep and Respiratory Physicians 97815244

Full Name: _____

DOB: _____/_____/_____

Commercial Drivers Licence: Yes/No

Email: _____

Phone/Mobile:_____

Height: _____ cm Weight: _____ kg

Address:_____

Medicare Number: _____/REF_____

Both STOP BANG and ESS scores MUST be completed to Qualify for a Medicare rebated Home Sleep Study (Medicare Item 12250)

Use the Following scale to choose the most appropriate answer:

0 - No Chance
1 - Slight Chance
2 - Moderate Chance
3 - High Chance

ESS Questionnaire - ***Patient must score 8 or more to qualify.***

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 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	**Total**

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Stop Bang Questionnaire - *Patient Must Score 3 or more to qualify*

Do you **S**nore loudly (loud enough to be heard through closed doors or your bed partner elbows you for snoring at night)?	○ Yes	○ No
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 choaking/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 shirt collar 17inches/ 43cm or larger? For female, Shirt collar 16inches /41cm or larger?	○ Yes	○ No
Is your **G**ender Male?	○ Yes	○ No
	Total	

Symptoms and Medical Conditions

- Hypertension
- Overweight
- Family History (OSA)
- Stroke/Tia
- COPD
- Cardiac Failure
- Atrial Fibrillation
- Clinical History
- Type II Diabetes
- Pacemaker
- Other

For a Referral to be Valid, please ensure the following details are completed and SIGNED.

Referring Dr.

Practice Name:

Provider no:

Email:

Phone:

Referring Dr Signature:

_____

Fax:

Referral Date: _____