Referral

Sleep & Respiratory Group

Specialists in Sleep Disorders, Respiratory & Thoracic Medicine

www.sleepgroup.com.au

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Brighton Main Office: Suite 2 at Cabrini, 243 New Street, 3186
Camberwell: 2, 1150 Toorak Rd (cnr Summerhill Rd)
Narre Warren at Southeast ENT: 509 Princes Highway
Berwick St John of God Hospital: 75 Kangan Drive

☐ **Consultation** or tele-health ☐ **Consultation** following sleep test ☐ Urgent: *to contact pt. ≤48hrs*

☐ **Laboratory Sleep Test:** comprehensive in-lab attended study.
Cabrini Brighton, Epworth Camberwell & Richmond, SEPH, Beleura Mornington.
Regionally: Wangaratta PH, Maryvale Morwell, Epworth Geelong.

☐ **Home Sleep Test.**
For suspected moderate to high risk of OSA.
Pts will be contacted to arrange test location.

☐ **Direct referral for sleep test: ESS** *(≥8)* **=** _____ ***AND*** **OSA-50** *(≥5)* **=** _____ ***OR*** **STOP-BANG** *(≥ 3)* **=** _____

Enter ESS, & OSA-50 or STOPBANG scores (& for in-Lab the Medicare reason) over page. Pts will be contacted to arrange location & eligibility.

☐ **Lung Function:** Spirometry pre & post bronchodilator (BD), & Gas transfer/DLCO

☐ Spirometry & BD only ☐ FeNO ☐ Bronchial Provocation Challenge - Mannitol

☐ Lung volumes -body box/plethysmography ☐ MIPs & MEPs ☐ MVV

☐ Oxygen Assessment Clinic: ABGs, 6MWT, SaO_2 ☐ ABGs ☐ 6MWT

☐ Other

Note that all inhalers should be avoided for 12 hours prior to testing, unless required, or instructed otherwise.

Patient

Surname _____ Given name(s) _____

Date of birth ___/___/_____ ☐ M ☐ F ☐ other Email _____

Address _____

Mobile _____ Phone _____ Title/preferred name _____

Medicare no. _____ Health Ins. Fund: _____ no. _____

Preferred type of communication: ☐ Mobile ☐ Phone ☐ Email DVA: _____

Clinical details _____

Comorbidities ☐Obesity ☐Diabetes ☐AF/rhythm ☐BP ☐IHD/Valve/Heart ☐COPD ☐Respiratory/Nasal ☐Neuro/TIA/Stroke/Mood ☐Nocturia

Doctor

(signature & date required)

Name _____ Provider no. _____

Address _____

Phone _____ Fax _____ Email _____

Signature _____ Date _____

Preferred communication: ☐ Email ☐ HL ☐ Fax other_____

Name **Birthdate:** **Todays date:**

Epworth Sleepiness Questionnaire

How likely are you to dose off or fall asleep in the following situations, in contrast to sitting and reading or just feeling tired? This refers to your recent / current way of life. Even if you have not done some of these things recently, try to determine how they would affect you.

Circle the response that best describes you:	Never	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. in a theatre or in a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	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 lunch without alcohol	0	1	2	3
In a car as a driver stopped for a few minutes in traffic	0	1	2	3
Score of 8 or more indicates moderate to high risk & enables Medicare rebate			**TOTAL = _____/24**	

OSA 50 Questionnaire

Waist circumference: Male > 102cm, Female > 88cm	3
Has your snoring ever bothered other people?	3
Has anyone noticed that you stop breathing during your sleep? Have apnoeas?	2
Are you aged 50 years or over?	2
Circle positive response, & add up: a score of 5 or more enables Medicare rebate **TOTAL**	**_____/10**

STOP-BANG Questionnaire

Do you snore loudly? Louder than talking or loud enough to be heard through closed doors?	1
Do you often feel tired, fatigued, or sleepy during the daytime?	1
Has anyone observed you stop breathing, apnoeas obstructions, or choking / gasping during sleep?	1
Do you have, or are being treated for, high BP?	1
BMI > 35 kg/m^2	1
Age > 50 years	1
Neck circumference: Men > 43cm, Females > 41cm	1
Male Gender	1
Circle / tick & then add up: a score 3 or more enables a Medicare rebate **TOTAL**	**_____/8**

Direct Referral for In-Laboratory Sleep Test requires a Medicare eligible reason (tick one or more that apply):

- ☐ home circumstances not appropriate eg children, heat, noise, cold, family duties, small bed, pets, partner snoring etc
- ☐ frequent movements, getting up, nocturia
- ☐ patient preference based on a concern or anxiety about location of study or where there is unreasonable cost or disruption based on distance to be travelled
- ☐ suspected parasomnia, movements, seizure disorder, paralysis, dream behaviours or bruxism
- ☐ full assessment of leg movements
- ☐ video needed
- ☐ home environment may cause recording failure
- ☐ suspected condition where recording of body position is considered to be essential and may not be recorded as part of an unattended sleep study
- ☐ previously failed or inconclusive home sleep study
- ☐ sleep technician intervention or attention required
- ☐ significant co-morbid conditions incl. neuromuscular disease / skeletal, heart failure, recent AMI / stroke / admission, or advanced respiratory disease where more complex disorders are likely
- ☐ full assessment of subtle abnormalities
- ☐ unsuitable home environment including unsafe environments or where patients are homeless
- ☐ intellectual disability or cognitive impairment
- ☐ physical disability with inadequate carer attendance
- ☐ suspected respiratory failure where attended measurements are required, including measurement of carbon dioxide partial pressures
- ☐ other: _____.

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