South Eastern Private Hospital

SLEEP STUDY REFERRAL

Unit Record Number

Family Name

Given Names

Date of Birth | Age

Sex | Room No.

OR USE LABEL

Corner of Heatherton Road and Princes Highway
Noble Park VIC 3174
Director: Dr Michael Ho

For all appointments and enquiries
Telephone: 9549 6555 / 9547 9133
Fax: 9549 6371
Email: sepsleepcentre@aurorahealth.com.au

Sleep Study Date:

Patient Information

Surname: DOB: / /

Given Names:

Address:

Postcode:

Telephone: Mobile:

Insurance Details

Health Fund: DVA / Medicare No:

Health Fund No: Hospital Cover: Circle if GOLD tier

Symptoms

- ☐ Disturbed sleep
- ☐ Disruptive snoring
- ☐ Nocturnal choking
- ☐ Witnessed apnoeas
- ☐ Unrefreshed sleep
- ☐ Daytime sleepiness

Relevant Medical Conditions

- ☐ Ischemic Heart Disease
- ☐ Hypertension
- ☐ Atrial fibrillation
- ☐ Cardiac failure
- ☐ Chronic respiratory failure
- ☐ COPD
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke / TIA
- ☐ Depression

Clinical History (optional):

Request for (please tick appropriately):

- ☐ Initial diagnostic sleep study (# 12203)
- ☐ Repeat diagnostic sleep study (# 12208)
- ☐ CPAP implementation sleep study (# 12204)
- ☐ CPAP treatment review sleep study (# 12205)
- ☐ BiPAP/O_2 titration sleep study (# 12207)
- ☐ Split diagnostic and CPAP titration sleep study
- ☐ Mandibular advancement splint sleep study
- ☐ Referral for follow-up consult with Sleep Physician
  Please specify (optional) Dr: _____

Suspected Sleep Disorders

- ☐ Obstructive Sleep Apnoea
- ☐ Central Sleep Apnoea
- ☐ Nocturnal hypoventilation
- ☐ Periodic limb movements
- ☐ Insomnia
- ☐ Others _____

Referring Doctor

Name: Provider No:

Address:

Telephone:

Referral Period: 3 months 12 months Indefinite

Referral Date: Signature:

For GP direct Diagnostic Sleep Study Referrals, please complete the two questionnaires on the back page.

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MR/SSR

Print Media Group – AHCSNFMR0SSR 04/23

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For GP direct referral, please complete the two questionnaires below to ensure the patient has a high probability for significant symptomatic obstructive sleep apnoea.

Epworth Sleepiness Scale

Please circle only one number per scenario: (0 = never, 1 = slightly, 2 = moderately, 3 = highly).

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
This refers to your usual way of life in recent times (last few months). Even if you have not done some of these things recently, try to work out how they would have affected you.

	Never	Slightly	Moderate	Highly
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	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 talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

*Scoring: Add the value of all circled numbers – Total must be **8 or higher** to be eligible for direct referral for initial sleep study, followed by Sleep Physician consultation.*
For patients with values < 8, they will be referred for a Sleep Physician consultation first.

TOTAL

OSA50

Please circle only one number per row

Obesity	**Is your waist circumference >102cms (male) or >88cms (female)?**	3
Snoring	**Has your snoring ever bothered other people?**	3
Apnoea	**Has anyone noticed that you stopped breathing during sleep?**	2
50	**Are you aged 50 years or over?**	2

*Scoring: Add the value of all circled numbers – Total must be **5 or higher** to be eligible for direct referral for initial sleep study, followed by Sleep Physician consultation.*
For patients with values < 5, they will be referred for a Sleep Physician consultation first.

TOTAL