MEDICAL SLEEP TEST

REQUEST FOR
Home Diagnostic Sleep Test Bulk-billed Level 2 PSG

Once completed, please send completed referral form to one of the following methods.

Fax: (02) 9133 2951
Email: admin@medsleeptest.com.au

Sleep Partner Store:

Referral To:

Name: Dr Philip Lee
MBBS (HONS) UNSW FRACP

Company: **Medical Sleep Test Pty Ltd**
Phone: (02) 9133 2950
Fax: (02) 9133 2951
Address: Shop 3, 242 Princes Hwy
CORRIMAL NSW 2518

Please see other Sleep Partner Locations via our Store Finder on https://www.medsleeptest.com.au/locations

Patient Details

Name: _____ ◯ **Male** ◯ **Female** **DOB:**

Email: _____ **Mobile:** _____

Address: _____

Medicare No. ☐☐☐☐☐☐☐☐☐☐/☐ **DVA** ☐☐☐☐☐☐☐☐☐ **Card Type:** -- Select --

Medicare Approved Assessment Conditions

1. Patient Aged 18+
2. Epworth Sleepiness Scale of 8+
3. STOP BANG of 4+ **OR** OSA50 of 5+
4. Home Sleep Study has not been claimed within the last 12 months from the date of this referral.
   We can proceed with a private sleep study if a home sleep study claim was made in the last 12 months from the date of this referral.

Sleep Assessment Tools

OSA50 Screening Questions - Tick all that apply *(Score out of 10 and the referral requires 5+)*

		Yes	No
Waist circumference* -Male> 102cm or Females >88cm	3 points	☐	☐
Snoring bothers others?	3 points	☐	☐
Witnessed apnoeas?	2 points	☐	☐
Age 50 or over?	2 points	☐	☐
Total OSA50 Score	0 **points**		

**Waist measurement to be measured at the level of the umbilicus*

STOPBANG Questionnaire - Tick all that apply *(Score out of 8 and the referral requires 4+)*
(Rate 0-3 to indicate chance of dozing)

		Yes	No
Does the patient **S**nore?	1 point	☐	☐
Does the patient feel **T**ired, fatigued or sleepy during the day time?	1 point	☐	☐
Has anyone **O**bserve the patient stop breathing or choking/gasping during their sleep?	1 point	☐	☐
Is the patient being treated for High Blood **P**ressure?	1 point	☐	☐
Is the patients **B**MI greater than 35?	1 point	☐	☐
Is the patient **A**ge 50 or older?	1 point	☐	☐
Is the patient's **N**eck circumference greater than 40cm?	1 point	☐	☐
Is the patient's **G**ender male?	1 point	☐	☐
Total STOP BANG Score	0 **points**		

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Epworth Sleepiness Scale (ESS) - Tick appropriately *(Score out of 24 and the referral requires 8+)*

In the following situations, how likely is the patient to doze off or fall asleep, in contrast to just feeling tired?
Use the numeric scale below to determine the likelihood of dozing off in each of the situations below.

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

Situations	0	1	2	3
Sitting and Reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place	☐	☐	☐	☐
As a passenger in a car for an hour with no break	☐	☐	☐	☐
Lying down in the afternoon	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch (without alcohol)	☐	☐	☐	☐
Stopping in traffic for a few minutes while driving a car	☐	☐	☐	☐
Total ESS Score	0 **Out of 24**			

Referral Reason

Tick all boxes that apply

- ☐ Witnessed apnoea or choking
- ☐ Regular loud snoring
- ☐ Regular Fatigue or Daytime
- ☐ Sleepiness Type II Diabetes
- ☐ Other
- ☐ Hypertension
- ☐ Cardiac Disease/Arrhythmia
- ☐ Obesity
- ☐ Neurological Issues
- ☐ Stroke
- ☐ Depression
- ☐ Frequent nocturia
- ☐ Sleepy driving

Referring Drs Details

Doctors Name: _____ **Provider No.** _____

Address: _____ **Practice Name:** _____

_____

Signature: _____ **Date:** _____

Patients with one or more of the below conditions are unsuitable for a home sleep study: Neuropsychological, severe intellectual or physical disability conditions or where video conformation is essential for diagnosis (parasomnias/RLS).

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