Home Sleep Test Referral - Peninsula CPAP Services

Address: 1/37 Dava Drive, Mornington 3931 & 1953 Lavers hill Cobden Road, Simpson 3266
Phone: 03 5986 7136 **Fax:** 03 8679 4448 **Email:** peninsulasleepstudies@outlook.com

Full Name: _____

DOB: _____/_____/_____

Phone/Mobile: _____

Email: _____

Medicare Number: _____/_____

Medicare Expiry: _____ / _____

DVA number: _____

REQUEST FOR REFERRAL - Please mark appropriate options:

- ☐ Home Sleep Study
- ☐ CPAP / APAP Trial for the treatment of sleep apnoea
- ☐ CPAP Therapy Review – pressure, compliance, mask review and full equipment check

Commercial Drivers Licence: Yes / No

Height: _____ cm Weight: _____ kg

Home Based Sleep Study
Medicare Item 12250

BULK BILLING REQUIRES: ☐ ESS 8 or more AND ☐ STOP BANG of 3 or more Or Private funding applies

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

How Likely are you to doze off (fall asleep) in the following Situations?

Use the following scale to choose the most appropriate answer

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

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 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 _____

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

Do you Snore 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 Tired, fatigued, or sleepy during the day (such as falling asleep during driving or talking to someone)?	○ Yes	○ No
Has anyone Observed you stop breathing or choaking/gasping during your sleep?	○ Yes	○ No
Do you have or are you being treated for high blood Pressure?	○ Yes	○ No
Is your Body mass index more than 35 kg/m2?	○ Yes	○ No
Are you Aged older than 50?	○ Yes	○ No
Is your Neck size large: For male shirt collar 17inches/ 43cm or larger? For female, Shirt collar 16inches /41cm or larger?	○ Yes	○ No
Is your Gender 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. Name: _____

Practice Name: _____

Provider no: _____

Address: _____

Email: _____

Phone: _____

Referring Dr Signature:

_____

Fax: _____

Referral Date: _____