

Sleep Study Referral

Referral Date:

PATIENT INFORMATION:

Name: _____

DOB: Gender: _____
D D M M Y Y Y Y M / F

Address: _____
 _____ Postcode: _____

Mobile: _____

Email: _____

Medicare:

Reference: Expiry: (DDYY)

DVA: _____ Gold White

REFERRING DOCTOR/PHYSICIAN DETAILS:

*This section must be completed for a valid referral

Name: _____

Surgery: _____

_____ Postcode: _____

Provider Number: _____

Phone: _____ Fax: _____

Email: _____

Doctors Signature: _____

Stamp:

BULK BILLING REQUIREMENTS : STOP-Bang score of ≥ 3 points or OSA50 ≥ 5 points and ESS ≥ 8 points Service Requested Level 2 PSG - Bulk Billed - Sleep Study (Item 12250) to confirm the diagnosis of OSA AND specialist consultation where deemed appropriate by the Sleep Physician.

CONTRAINDICATIONS: Please confirm that the patient does not experience any contraindications for a home based sleep study listed: Significant intellectual / cognitive impairment, significant physical disability without a carer's assistance, neuromuscular disease, advanced heart failure, advanced / Type II respiratory failure, seizure disorders, parasomnias, or an unsafe/undesirable home environment.
 Tick to confirm no contraindication Previous sleep study: Yes No Date:

STOP-Bang : A score of ≥ 3

- S** Does the patient **SNORE** loudly?
 - T** Does the patient often feel **TIRED**, fatigued or sleep during daytime?
 - O** Has anyone **OBSERVED** the patient stop breathing during sleep?
 - P** Does the patient have or is the patient being treated for high blood **PRESSURE**?
 - B** Does the patient have a **BMI** more than 35?
 - A** **AGE** over 50 years old?
 - N** **NECK** circumference (shirt size) more than 40cm / 16 inches?
 - G** Is the patient a **MALE**?
- TOTAL score**
Each question is 1 point

OSA50 : A score of ≥ 5

- O** Obesity (3 points) Waist circumference: Male >102cm or Female >88cm
 - S** Snoring (3 points) Has your patient's snoring ever bothered other people?
 - A** Apnea (2 points) Has anyone noticed that your patient stopped breathing during sleep?
 - 50** (2 points) Is your patient aged 50 years or over?
- TOTAL score**

Epworth Sleepiness Scale Questionnaire: A score of ≥ 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 = Would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing
1 ChungChung F et al/Anaesthesiology 2008 & Br J Anaesth 2012; 2 Chai-Coetzer CL ed al Thorax 2011; 3 Johns M Sleep 1991

- Situations**
- Sitting and Reading
 - Watching TV
 - Sitting inactive in a public place (eg. theatre or meeting)
 - As a passenger in a car for an hour with no break
 - Sitting and talking to someone
 - Laying down in the afternoon when circumstances permit
 - Sitting quietly after lunch (without alcohol)
 - In a car, while stopped for a few minutes in traffic
- TOTAL SCORE (add up score of total responses)**

Tick one score for each scenario

0	1	2	3
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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DFRM-SMTG-2164-13

SYMPTOMS AND MEDICAL CONDITIONS

Diagnostic Sleep Study - to confirm diagnosis of Obstructive Sleep Apnea and specialist consultation where deemed appropriate by the sleep physician. Clinical history please tick any that apply;

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Overweight | <input type="checkbox"/> Family history (OSA) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cardiac failure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Witnessed apnea or choking | <input type="checkbox"/> Sleepy Driving |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Type II Diabetes | <input type="checkbox"/> Regular Fatigue or Daytime Sleepiness | <input type="checkbox"/> Neurological Issues |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Regular Loud Snoring | <input type="checkbox"/> Frequent Nocturia |

Other: _____

Patient Height (cm) =

Weight (kg) =

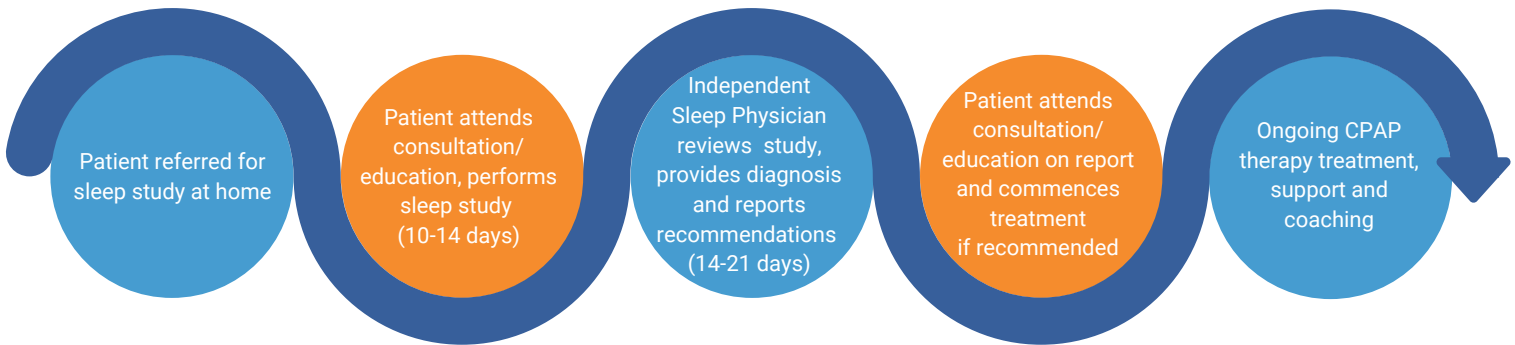
BMI (kg/m2) =

YOUR SLEEP STUDY APPOINTMENT

- Our staff will contact your patient to book a convenient appointment if the referral is sent using one of the below options.
- We provide comprehensive collection of high-quality sleep data, simple to use and comfortable for patients in home testing.
- Our studies are scored by a sleep scientist and reported on by local sleep physicians.
- If you need to cancel or reschedule we kindly ask that you give 48 hours notice.
- If your sleep study is self funded, a private study fee will be payable.









PATIENT PATHWAY



AIR LIQUIDE HEALTHCARE - CONTACT US

Australia's largest facilitator of home sleep apnea studies and therapy. Our Patient Pathway is an end-to-end solution for the diagnosis, treatment and ongoing management of Obstructive Sleep Apnea.

-  1300 36 02 02
-  1800 270 779
-  sleepstudy@airliquide.com
-  <https://sleepsolutionsaustralia.com>
-  Health Link: **alhealth**
-  Medical Objects ID: **LA2015000JD**



To Download our referral to your Practice software visit;
<https://www.airliquidehealthcare.com.au/sleep-study-referral-rtf-files>

