

Referral to Sleep Unit

Surname:

Given Name:

Address:

Phone / Mob:

Gender: M F

Date of Birth:



Clinical Details

Please Indicate your reasons for referral:

.....
.....
.....

Other relevant medical conditions:

.....
.....
.....

Medicare Requirements for sleep testing have changed

As of March 2021, patients referred directly for a sleep study must report symptomatic sleepiness via an Epworth Sleepiness Scale score of ≥ 8 and have moderate to severe likelihood of Obstructive Sleep Apnoea (OSA) and STOP BANG score of ≥ 3 .

To determine if your patient is eligible for a diagnostic sleep study, please complete the screening tools in the next page and select option 1. Alternatively, select Option 2 for referral to a Sleep or Respiratory Physician for further investigation into symptoms or for additional testing including CPAP studies.

Referral for sleep investigation

- Option 1—Sleep study (Complete ESS and STOP BANG)
 Option 2—Physician consultation and sleep study

Ensure the following box is ticked and the referring doctor details are completed. The sleep study cannot be booked without this information.

- I would like The Victorian Rehabilitation Centre to arrange an appointment for my patient with the reporting sleep physician to discuss the result & arrange further management as indicated.

Doctors Name:

Provider Number:

Signature:

Date:

SLEEP SPECIALIST USE ONLY Sleep study approved: Yes No

Provider Number:

Study Type:

Physician Name:

Signature:

Please fax or email this form directly to The Victorian Rehabilitation Centre.

The Victorian Rehabilitation Centre

499 Springvale Road, Glen Waverley VIC 3150 | P 03 9501 8865 | F 03 9566 2848 | E vicrehab.sleep@healthscope.com.au

thevictorianrehabilitationcentre.com.au

ABN 61 069 962 698

STOP-BANG Questionnaire (must be completed by the referring doctor)

		Yes	No
1. Snoring	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Tired	Do you often feel tired, fatigued, or sleepy during daytime?	<input type="checkbox"/>	<input type="checkbox"/>
3. Observed	Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
4. Blood pressure	Do you have or are you being treated for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
5. BMI	BMI more than 35kg/m ² ?	<input type="checkbox"/>	<input type="checkbox"/>
6. Age	Age over 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>
7. Neck circumference	Neck circumference greater than 40cm?	<input type="checkbox"/>	<input type="checkbox"/>
8. Gender	Gender male?	<input type="checkbox"/>	<input type="checkbox"/>
Total Score:		/8	

The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to Just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you. Choose the most appropriate number for each situation by putting a Check for each question.

Situation:	0 = Never doze	1 = slight chance of dozing	2 = Moderate chance of dozing	3 = High chance of dozing
1. Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sitting, inactive in a public place (eg. theatre or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sitting talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Score:		/24		