Referral to Sleep Unit

The Victorian Rehabilitation Centre
by Healthscope

Surname: Given Name:

Address: Phone / Mob:

Gender: ☐ M ☐ F Date of Birth:

Accredited for compliance with ASA Standard for Sleep Disorders Services

Clinical Details

Please Indicate your reasons for referral:

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.....

.....

Other relevant medical conditions:

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.....

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 8868| **F** 03 9566 2848 | **E** vicrehab.sleep@healthscope.com.au
thevictorianrehabilitationcentre.com.au
ABN 61 069 962 698

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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)?	☐	☐
2. Tired	Do you often feel tired, fatigued, or sleepy during daytime?	☐	☐
3. Observed	Has anyone observed you stop breathing during your sleep?	☐	☐
4. Blood pressure	Do you have or are you being treated for high blood pressure?	☐	☐
5. BMI	BMI more than 35kg/m2?	☐	☐
6. Age	Age over 50 years old?	☐	☐
7. Neck circumference	Neck circumference greater than 40cm?	☐	☐
8. Gender	Gender male?	☐	☐
	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	☐	☐	☐	☐
2. Watching TV	☐	☐	☐	☐
3. Sitting, inactive in a public place (eg. theatre or a meeting)	☐	☐	☐	☐
4. As a passenger in a car for an hour without a break	☐	☐	☐	☐
5. Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
6. Sitting talking to someone	☐	☐	☐	☐
7. Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
8. In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐
Total Score:		**/24**		

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