SLEEP WELL CPAP SERVICES – MED ANALYSIS

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Medical Services Referral: **Referral Date: / /20 .**

[Please confirm eligibility criteria below – ESS and OSA 50 must be completed]

Patient Details: **DOB: / /** **Gender:**

Name: ____________________________________

Phone/Mobile: ______________________________

Address: ___________________________________

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Medicare # ___________________

Pt. Item # ___________

Expiry Date: _________________

[Only one [1] Sleep test is permitted in a 12-month period]

Services Requested:

	Ambulatory Sleep Study [Full PSG]		ECG 24hr Holter Monitoring
	CPAP set/up/trial for diagnosed OSA		Specialist Tele-Health Consultation

Eligibility Criteria for Ambulatory Sleep Study:

	Witnessed Apnea or Choking		Regular Fatigue or Sleepiness
	Regular loud snoring		CV Risk – Obesity [BMI > 30], Hypertension, Cardiac disease, Diabetes

EPWORTH SLEEPINESS SCALE ("ESS")

In the following situations, how likely are you to doze off or fall asleep, in contrast to just feeling tired? Use the following scale to choose **one** most appropriate number for each situation.

SITUATION	Chance of dozing or sleeping			
	Never	**Slight**	**Mod**	**High**
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place	☐ 0	☐ 1	☐ 2	☐ 3
Being a passenger in a car for an hour	☐ 0	☐ 1	☐ 2	☐ 3
Lying down in the afternoon	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after lunch (without alcohol)	☐ 0	☐ 1	☐ 2	☐ 3
Stopping for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
YOUR TOTAL ESS	**/ 24**			

OSA 50 Screening Questionnaire		If yes, SCORE
OBESITY	Waist circumference - Male > 102cm Females > 88cm	**3**
SNORING	Has your snoring ever bothered other people?	**3**
APNOEAS	Has anyone noticed you stop breathing during your sleep?	**2**
50	Are you aged 50 years or over?	**2**
	TOTAL SCORE	**/ 10**

STAMP:

Referring General Practitioner:

Doctor: __________________________ Provider #: _______________

Signature: _________________________ Address: ________________________

Sleep Technician to complete:

Patient Height: __________ Patient Weight: ____________ BMI: _______

STOP BANG SCORE: ____/8

Notes:

PLEASE FAX REFERRAL – 07 3009 0655