REFERRAL FORM FOR SLEEP PHYSICIAN TO REVIEW



Formerly **ResSleep**

# Please send your referral to us by Fax: 1300 605 705 or Email: [admin@mysleep.com.au](mailto:admin@mysleep.com.au) or Medical Objects: mySleep

## Our staff will contact the patient to book an appointment or your patient can call **1300 605 700**.

Patient name ........................................................................... D.O.B. ........................................................ Gold Card DVA: 🞎YES 🞎NO

Email ................................................................................... **► Phone** Commercial Drivers Licence: 🞎YES 🞎NO

SERVICE REQUIRED **(Mandatory)**

○

##### Indicates essential information required

* **Home Sleep Study** *Pre-Assessment consultation with Sleep Physician, if required.*

1

* **Sleep Physician Consultation** *Consultation fees and wait times will vary depending on QLD location*

**(Mandatory)**

ESS QUESTIONNAIRE

How likely are you to doze or fall asleep in the following situations:

# Use the following scale to choose the most appropriate answer:



2

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 a 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** |
| MEDICARE ELIGIBILITY = 8+ |  | TOT | AL | 0 | / | 24 |  |  |

## - No chance

* 1. - Slight chance
  2. - Moderate chance
  3. - High chance

If patient has 8+ on ESS CHOOSE OSA50 or STOPBANG

*(If patient has ESS < 8* ***do NOT continue* -** *send the referral to us for assessment of other options)*



OSA50 QUESTIONNAIRE

STOPBANG QUESTIONNAIRE

|  |  |  |  |
| --- | --- | --- | --- |
| Obesity Is your waist\* circumference over 102cm (M) or over 88cm (F)? | | **Yes** (+3) | **No** |
| Snore Has your snoring ever bothered people? | | **Yes** (+3) | **No** |
| Apnea Has anyone noticed that you stop breathing during your sleep? | | **Yes** (+2) | **No** |
| 50 You are aged 50 years or | over? | **Yes** (+2) | **No** |
| MEDICARE ELIGIBILITY = 5+ | TOTAL 0 | | / 10 |

#### \* Waist measurement to be measured at the level of the umbilicus



3

OR

|  |  |  |  |
| --- | --- | --- | --- |
| Do you Snore loudly (loud enough to be heard **Yes No**  through closed doors or your bed-partner elbows you for snoring at night)? | | | |
| Do you often feel Tired, fatigued, or sleepy **Yes No**  during the day (such as falling asleep during driving or talking to someone)? | | | |
| Has anyone Observed you stop breathing or **Yes No**  choking/gasping during your sleep? | | | |
| Do you have or are you being treated for high blood Pressure? |  | **Yes No** | |
| Is your Body mass index more than 35kg/m2? | **Yes Yes Yes**  **Yes** | **No** |
| Are you Aged older than 50? | **No** |
| Is your Neck size large: Is your shirt collar 43cm or larger (M)*\*\** ? or 41cm or larger (F)? | **No** |
| Is your Gender male? | **No** |
| MEDICARE ELIGIBILITY = 4+ YES TOTAL 0 / 8 | | | |

*\*\* Measured around Adams Apple*

OTHER REFERRAL REASONS **(Optional)**



Type II Diabetes Family history (OSA)

4

Depression Morning headaches

Stroke / TIA Daytime sleepiness



Insomnia Hypertension



Cardiac Arrhythmia Cardiovascular Disease



Other *(Relevant Health History - Optional, attach notes to this referral)*:



**No**

**Yes**

Does your patient have neuromuscular disease, heart failure or advanced respiratory disease, or do you suspect a parasomnia, seizure disorder or respiratory failure? If yes, please provide details

FOR THIS REFERRAL TO BE VALID, PLEASE ENSURE THE FOLLOWING DETAILS ARE COMPLETED:

* **Referring Dr. Name:** Phone: Fax: Provider Number: Email: Practice Name

5

* **Referral Date:**
* **Signature:**

### Address: \_\_\_\_

\_\_\_\_\_ \_\_\_\_\_

* *Indicates essential information required*

IF DIAGNOSED WITH OSA CHOOSE A PATHWAY

**CPAP/APAP Treatment Trial** *as recommended by a sleep physician to treat sleep apnea* **Independent Sleep Physician Consultation** *to discuss results and all treatment options* **Manage Patient Independently** *(the patient's treatment will be the responsibility of a GP or an alternative health professional)* **Mandibular Advancement Splint** *as recommended by a sleep physician to treat snoring and sleep apnea (we can recommend dentists)* **Positional Avoidance Therapy Trial** *as recommended by a sleep physician to treat sleep apnea* **CPAP Therapy Review** *for any patient on treatment that may need assistance***Supply of 'DVA approved' Equipment and Services** *\*For eligible DVA patients*



**UPPER MT GRAVATT GREENSLOPES NORTH LAKES CHERMSIDE**

The assessment and appropriateness of home studies directly requested by GP’s are overseen by a supervising Sleep Physician.

Based on these assessments and the study findings, certain complex patients may require a Sleep Physician Consultation. These can be arranged by having rapid access to independent Local Sleep & Respiratory Physicians in Brisbane.

Medicare recommends a patient is seen by a health professional prior to treatment, please recall every patient and send a referral indicating treatment pathway required.

For more information or clarification on referring patients please contact your dedicated local Representative or call 1300 605 700.