



Sleep Centre Booking Form

Unit Record Number				
Surname				
Given Names				
Date of Birth	Sex			
Room No. Doctor				
OR LISE PATIENT I AREI				

Submit Form via En	nail or Fax Compl	eted Form to 03 5	59 75 9144			
PATIENT DETAILS						
Title: Surname:		Give	n Names:			
Date of Birth:		Sex: ☐ Male ☐] Female			
Phone: (H)		(M)				
Medicare Number:			Reference N	lumber:		
Health Fund Name:			Health Fund	Number:		
STUDY REQUESTED						
☐ Diagnostic Sleep S	Study CPAP Im	plementation Study	☐ CPAP	Review Study MSLT MSLT] MWT	
STOP BANG Ques	tionnaire (must b	e completed by th	ne referrinç	g doctor)		
1. Snoring	Do you snore loudly (Louder than talking or loud enough to be heard through closed doors)?			Yes	No	
2. Tired	Do you often feel t	ired, fatigued, or sle	epy during	daytime?	Yes	No
3. Observed	Has anyone obser	ved you stop breath	ning during y	your sleep?	Yes	No
4. Blood pressure	Do you have or are you being treated for high blood pressure?		Yes	No		
5. BMI	BMI more than 35 kg/m²?		Yes	No		
6. Age	Age over 50 yr old?		Yes	No		
7. Neck circumference	Neck circumference greater than 40cm?		Yes	No		
8. Gender	Gender male?			Yes	No	
Calculate one point for each yes. STOP BANG Score of < 4 suggests that the pt is not at high risk of severe OSA. MBS no longer fund Sleep Studies (IP or home based) if score < 4. If these measures are not met suggest consideration of other causes of the pt's symptoms ± referral to a sleep physician.						
Epworth Sleepiness	Scale (must be co	ompleted by referri	ng doctor, s	see over)		
Past Medical Histo	ry					
Obstructive sleep apnoea risk factors;		t disease	☐ Cerebrovascular disease	e		
☐ Obesity ☐ I	Hypertension ☐ Lung disease ☐ Cognitive impairment		☐ Cognitive impairment			
☐ Depression ☐			☐ Suspected respiratory fa	ilure		
		☐ Hypothyroidism		☐ Atrial fibrillation		
☐ Other:		,, ,				
Analgesic / Psychotropic Medications:						
	•					
Referring Doctors D	etails:		Additional	Reports to:		
Referring Doctors Details: Name of referring Doctor:		Name:	Пороно ю.			
Traine of referring D			i tailio.			
Provider Number: Date:						
Referring Doctor Signature:		Address:				

Created: October 2018 Issue Date: October 2018 Page 1 of 2

Beleura Private Hospital
Part of Ramsay Health Care

Epworth Sleepiness Scale

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OR USE PATIENT LABEL			

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze

1 = slight chance dozing

2 = moderate chance dozing

3 = high chance dozing

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL =	/ 24

MBS will only fund a Sleep Study if STOP BANG \geq 4 AND ESS \geq 8. If these measures are not met then I suggest consideration of other causes for patient's symptoms \pm referral to Sleep Physician.

Created: October 2018 Version: 2 Issue Date: October 2018 Page 2 of 2