Home Sleep Test Referral - Rosebud CPAP Services

Full Name: _____ DOB: _____/_____/_____ Commercial Drivers Licence: Yes/No

Email: _____ Phone/Mobile:_____

Height: _____ cm Weight: _____ kg

Address: _____

Request for a referral (Please mark appropriate options) Medicare Number: _____/_____

- ○ Home sleep Study Pension/ Health Care Card No:_____
- ○ CPAP Therapy Review (pressure, compliance, mask review & full equipment check)
- ○ CPAP/APAP trail for the treatment of sleep apnea

Both STOP BANG AND ESS scores MUST be completed to Qualify for a Medicare rebated Home Sleep Study
(Medicare Item 12250)

ESS Questionnaire - *Patient must score 8 or more to qualify.*

How Likely are you to doze off (fall asleep) in the following Situations?

Use the following scale to choose the most appropriate answer

0- No chance
1- Slight chance
2- Moderate chance
3- High chance

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

Total _____

Stop Bang Questionnaire - *Patient Must Score 3 or more to qualify*

Do you **S**nore loudly (loud enough to be heard through closed doors or your bed partner elbows you for snoring at night)?	○ Yes	○ No
Do you often feel **T**ired, fatigued, or sleepy during the day (such as falling asleep during driving or talking to someone)?	○ Yes	○ No
Has anyone **O**bserved you stop breathing or choaking/gasping during your sleep?	○ Yes	○ No
Do you have or are you being treated for high blood **P**ressure?	○ Yes	○ No
Is your **B**ody mass index more than 35 kg/m2?	○ Yes	○ No
Are you **A**ged older than 50?	○ Yes	○ No
Is your **N**eck size large: For male shirt collar 17inches/ 43cm or larger? For female, Shirt collar 16inches /41cm or larger?	○ Yes	○ No
Is your **G**ender Male?	○ Yes	○ No

Total _____

Symptoms and Medical Conditions

- ☐ Hypertension ☐ Overweight ☐ Family History (OSA) ☐ Stroke/Tia ☐ COPD
- ☐ Cardiac Failure ☐ Atrial Fibrillation ☐ Clinical History ☐ Type II Diabetes ☐ Pacemaker
- ☐ Other

For a Referral to be Valid, please ensure the following details are completed and SIGNED.

Referring Dr. Name: _____ Practice Name: _____

Provider no: _____ Address: _____

Email: _____ Phone: _____

Referring Dr Signature:

_____

Fax: _____

Referral Date: _____

Address: 215 Jetty Road, Rosebud 3939, 1/37 Dava Drive, Mornington 3931, 1953 Cobden Lavershill Road, Simpson 3266
Phone: 03 5986 7136 **Fax**: 03 8679 4448 **Email:** rosebudsleepstudies@outlook.com