Email Referral Form to:

NSD/Medical Director - Dr Peter Solin MBBS FRACP PhD
- Respiratory & Sleep Disorders Physician

C/- CPAP Shop Cairns
Level 2 D, 5 Upward Street, Flecker House
CAIRNS QLD 4870
sales@cpapshop.com.au
Ph: 07 4031 6042

national Sleep Diagnostics
Sleep well, breathe easy.

PO Box 115 Oakleigh, VIC 3166
Ph: 1300 852 997 Fax: 1300 852 998
Email: info@sleepdiagnostics.com.au

Referral - Ambulatory Home Sleep Test/Telehealth Consultation

Patient Information

Surname		D.O.B.		☐ Male ☐ Female	
Given Names					
Address				Postcode	
Email				Phone	
Medicare/DVA No				Private health insurance ☐ Yes ☐ No	

Indications, Symptoms and Health Comorbidities

In order to meet Medicare requirements, patients should have a high probability of moderate to severe OSA using approved assessment tools. Please tick or write the scores below from the eligible questionnaires):

Epworth Sleepiness Score ≥ 8 ☐ **AND** OSA50 ≥ 5 ☐

OR

STOP-BANG ≥ 3 ☐

OR

BERLIN (tick if positive) ☐

Additional details: _____

Telehealth Consultation ☐ Yes **Ambulatory Home Sleep Test** ☐ Yes

Referring Doctor

Date		Provider No.	
Name			
Address			
		Postcode	
Phone		Fax	
Email		Signature	

***Report Preference*:** Mail ☐ Fax ☐ Email ☐ HealthLink ☐

Epworth Sleepiness Questionnaire

How likely are you to dose off or fall asleep in the following situations, in contrast to sitting and reading just feeling tired? This refers to your recent / current way of life. Even if you have not done some of these things recently, try to determine how they would affect you.

Circle the response that best describes you:	Never	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	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 lunch without alcohol	0	1	2	3
In a car as a driver stopped for a few minutes in traffic	0	1	2	3
		Total =	**_____/24**	

OSA50

Obesity: Waist circumference (male > 102cm, female > 88cm)	+3	
Snoring: Has your snoring ever bothered other people?	+3	
Apnoeas: Has anyone noticed that you stop breathing during your sleep?	+2	
50: Are you aged 50 years or over?	+2	
TOTAL (5 points or more indicates moderate to high risk)		**_____/10**

STOP-BANG

Do you **s**nore loudly? Louder than talking or loud enough to be heard through closed doors?	+1	
Do you often feel **t**ired, fatigued, or sleepy during the daytime?	+1	
Has anyone **o**bserved you stop breathing or choking/gasping during sleep?	+1	
Do you have (or are you being treated for) high blood **p**ressure?	+1	
BMI > 35 kg/m2	+1	
Age > 50 years	+1	
Neck circumference > 43 cm (M) Neck circumference > 41 cm (F)	+1	
Gender: Male?	+1	
TOTAL (3 points or more indicates moderate to high risk)		**_____/8**

For the Berlin Questionnaire visit www.sleepdiagnostics.com.au/berlinquestionnaire