

► **Patient name** D.O.B. DVA Gold Card:
 Email ► **Phone** Commercial Driver: YES NO
 NDIS patient: YES NO
 QHealth patient: YES NO

SERVICE REQUIRED

► Indicates essential information required

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Home Sleep Study

Complete Section 2 and Section 3 to assess if your patient is eligible to be Medicare Bulk Billed.

ESS QUESTIONNAIRE (Mandatory)

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

Sitting and reading	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Watching television	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sitting inactive, in a public space	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Lying down to rest in the afternoon when circumstances permit	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sitting and talking to someone	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sitting quietly after a lunch without alcohol	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
As a passenger in a car for an hour without a break	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
In a car, while stopped for a few minutes in traffic	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
MEDICARE ELIGIBILITY IS = ≥ 8	TOTAL		/ 24	

Use the following scale to choose the most appropriate answer:

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

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If patient has ≥ 8 on ESS **CHOOSE EITHER 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)?	<input type="radio"/> Yes (+3)	<input type="radio"/> No
Snore	Has your snoring ever bothered people?	<input type="radio"/> Yes (+3)	<input type="radio"/> No
Apnea	Has anyone noticed that you stop breathing during your sleep?	<input type="radio"/> Yes (+2)	<input type="radio"/> No
50	You are aged 50 years or over?	<input type="radio"/> Yes (+2)	<input type="radio"/> No
MEDICARE ELIGIBILITY = ≥ 5		TOTAL / 10	

OR

	Do you S nore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?	<input type="radio"/> Yes (+1)	<input type="radio"/> No
	Do you often feel T ired, fatigued, or sleepy during the day (such as falling asleep during driving or talking to someone)?	<input type="radio"/> Yes (+1)	<input type="radio"/> No
	Has anyone O bserved you stop breathing or choking/gasping during your sleep?	<input type="radio"/> Yes (+1)	<input type="radio"/> No
	Do you have or are you being treated for high blood P ressure?	<input type="radio"/> Yes (+1)	<input type="radio"/> No
	Is your B ody mass index more than 35kg/m ² ?	<input type="radio"/> Yes (+1)	<input type="radio"/> No
	Are you A ged older than 50?	<input type="radio"/> Yes (+1)	<input type="radio"/> No
	Is your N eck size large: Is your shirt collar 43cm or larger (M)**? or 41cm or larger (F)?	<input type="radio"/> Yes (+1)	<input type="radio"/> No
	Is your G ender male?	<input type="radio"/> Yes (+1)	<input type="radio"/> No
MEDICARE ELIGIBILITY = ≥ 3		YES TOTAL / 8	

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* Waist measurement to be measured at the level of the umbilicus
 ** Measured around Adams Apple

CONTRAINDICATIONS (Mandatory)

Does your patient have a physical disability with inadequate carer attendance, intellectual disability or cognitive impairment or has an unsuitable home environment?	<input type="radio"/> Yes	<input type="radio"/> No
Does your patient have neuromuscular disease, heart failure or advanced/suspected respiratory disease, suspected parasomnia or seizure disorder?	<input type="radio"/> Yes	<input type="radio"/> No
Has the patient had a previously failed or inconclusive home sleep study?	<input type="radio"/> Yes	<input type="radio"/> No

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OTHER REFERRAL REASONS (Optional)

- Type II Diabetes
- Depression
- Stroke / TIA
- Insomnia
- Cardiac Arrhythmia
- Family history (OSA)
- Morning headaches
- Daytime sleepiness
- Hypertension
- Cardiovascular Disease

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

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

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

► **Referral Date:** _____
 ► **Signature:** _____
 ► Indicates essential information required

Manage Patient Independently (discussing the patient's sleep study results and treatment will be the responsibility of the GP or an alternative health professional)

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. This 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.

To book in or for more information or clarification on referring patients please contact your dedicated local Representative or call us on **1300 605 700**

Upper Mt Gravatt
1722 Logan Rd
QLD 4122

Greenslopes
496 Logan Rd
QLD 4120

North Lakes
1/100 Flinders Parade
QLD 4509

Chermside
960 Gympie Rd
QLD 4032