RHC100.14
Admission Referral

Beleura Private Hospital
Part of Ramsay Health Care

Sleep Centre Booking Form

Unit Record Number

Surname

Given Names

Date of Birth

Sex

Room No.

Doctor

OR USE PATIENT LABEL

Submit Form via Email or Fax Completed Form to 03 59 75 9144

PATIENT DETAILS

Title:_____ Surname: _____ Given Names: _____

Date of Birth: Sex: ☐ Male ☐ Female

Phone: (H)_____ (M) _____

Medicare Number:_____ Reference Number: _____

Health Fund Name:_____ Health Fund Number: _____

STUDY REQUESTED

☐ Diagnostic Sleep Study ☐ CPAP Implementation Study ☐ CPAP Review Study ☐ MSLT ☐ MWT

STOP BANG Questionnaire (must be completed by the referring 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 tired, fatigued, or sleepy during daytime?	☐ Yes	☐ No
3. Observed	Has anyone observed you stop breathing during 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/m^2?	☐ 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 completed by referring doctor, see over)

Past Medical History

Obstructive sleep apnoea risk factors;

☐ Ischaemic heart disease ☐ Cerebrovascular disease

☐ Obesity ☐ Hypertension ☐ Lung disease ☐ Cognitive impairment

☐ Depression ☐ Diabetes ☐ Cardiomyopathy/CCF ☐ Suspected respiratory failure

☐ Hypothyroidism ☐ Atrial fibrillation

☐ Other:

Analgesic / Psychotropic Medications:

Referring Doctors Details:	Additional Reports to:
Name of referring Doctor:	Name:
Provider Number: Date:	
Referring Doctor Signature:	Address:

BINDING MARGIN - DO NOT WRITE

SLEEP CENTRE BOOKING FORM

MR/391

Beleura Private Hospital
Part of Ramsay Health Care

Epworth Sleepiness Scale

Unit Record Number

Surname _____

Given Names _____

Date of Birth

Sex

Room No.

Doctor _____

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

EPWORTH SLEEPINESS SCALE

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