REFERRAL FORM | FAX TO 07 3381 9025 | We will contact your patient for the next available appointment. Thank you.

Patient name _____**DOB**_____

Phone _____ **Commercial Driver's license: Yes No**

Address _____

NEXUS HEALTHCARE
Ph (07) 3708-3233 Fax (07) 3381 9025
Email: info@SleepStudyBrisbane.com.au

REQUEST FOR HOME SLEEP STUDY AND RESPIRATORY PHYSICIANS *(Please mark appropriate circle/s)*

◯ **Home sleep study** – This referral covers a Home Sleep Study supported by Medicare Item 12250.

◯ **Sleep physician consultations** – *Medicare and DVA rebates apply. Available at selected sites only. Consultation fee and wait times will vary*.

ESS AND OSA 50 Screening Questionnaire (Both requirements must be met to be eligible for Medicare Item 12250

ESS Epworth Sleepiness Scale: For a Medicare-subsidised Home Sleep Study, a patient must score 8 or more on the following.

How likely are you to doze off in the following situations?

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

Use the following scale to choose the most appropriate answer:
0 – No chance
1 – Slight chance
2 – Moderate chance
3 – High chance

SCORES _____ _____ _____ _____ TOTAL SCORE _____

OSA Obstructive Sleep Apnea - 50 Screening
For a Medicare-subsidised Home Sleep Study, the OSA 50 Screening must be ≥ 5

		Please circle
Obesity	Waist circumference* - Male > 102 cm or Female > 88 cm	3
Snoring	Has your snoring ever bothered other people?	3
Apnoeas	Has anyone noticed that you stop breathing during your sleep?	2
50 Age	Are you aged 50 years or over?	2
	TOTAL SCORE	_____ / 10points

SYMPTOMS (Please mark appropriate circle/s)

◯ Snoring ◯ Witness apneas / nocturnal gasping / choking ◯ Daytime lethargy / Sleepiness ◯ Cognitive Impairment
◯ Waking with headache ◯ Weight gain ◯ Restless sleep ◯ Insomnia ◯ Irritability

RELEVANT MEDICAL CONDITIONS (Please mark appropriate circle/s)

◯ Hypertension ◯ Cardiac failure ◯ Store / TIA ◯ COPD ◯ Overweight ◯ Pacemaker ◯ Type II Diabetes
◯ Atrial fibrillation ◯ Family history (OSA) ◯ Clinical History (optional, attach notes to this referral) ◯ Other_____

THERAPY REQUIRED (Please mark appropriate circle/s)

◯ **CPAP/APAP treatment trial** for the treatment of sleep apnea
◯ **CPAP therapy review with oximetry** *(pressure, compliance, mask review & full equipment check)*
◯ **Supply of DVA approved equipment and service** * *For eligible DVA patients*
◯ **Mandibular advancement oral device** for the treatment of snoring and sleep apnea (*Assessed & fitted by qualified dentist.)*

For this referral to be valid, please ensure the following details are completed:

Referring Dr. Name
Practice Name
Address
Email
Referring Dr. Signature _____

Provider Number _____
Referral date _____, _____, _____
Phone _____
Fax _____