Ramsay Health Care

SLEEP CENTRE DIRECT REFERRAL FORM

PATIENT DETAILS

Unit Record Number: _____

Family Name: _____

Given Name(s): _____

Date of Birth: _____ Sex: _____

Doctor(s): _____

(ATTACH PATIENT ID LABEL)

WRP100120

BINDING MARGIN - DO NOT WRITE

PATIENT

Name: ..... DOB: ...../...../.....

Phone: ..... Email: .....

Address: .....

Gender: ☐ M ☐ F Does the patient have private health insurance? ☐ Yes ☐ No

Preferred location (can select more than one):

☐ Mitcham Private Hospital ☐ Warringal Private Hospital (HEIDELBERG) ☐ Northern Private Hospital (EPPING)

☐ Wangaratta Private Hospital ☐ Albury Wodonga Private Hospital

The following information MUST be completed in order to assess a patient's eligibility for an in-hospital overnight sleep study as indicated by current regulatory guidelines.

Patient's with an OSA-50 score of ≥5 and an ESS score of ≥8 can be directly referred for in-hospital polysomnography. The assessment for potential contraindications to an unattended sleep study is to be undertaken by the referring practitioner and indicated below.

OSA-50 QUESTIONNAIRE Chai-Coetzer CL et al. Thorax 2011: 66: 213-9

	If Yes, score
Obesity: Waist circumference for Males >102cm or Females >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 or over?	2
Total score:	/ 10

THE EPWORTH SLEEPINESS SCALE Johns MW, Sleep 1991: 14: 50-55

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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. Choose the **most appropriate option** for each situation by putting an **X** in one box for each question.

SITUATION	Would Never Doze (0)	Slight Chance of Dozing (1)	Moderate Chance of Dozing (2)	High Chance of Dozing (3)
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, inactive in a public place (eg. theatre or a meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐
			TOTAL:	**/24**

Requires an attended in-hospital study based on one or more of the following

☐ Intellectual disability or cognitive impairment
☐ Significant relevant co-morbidities
☐ Suspected parasomnia or seizure disorder
☐ Failed or inconclusive unattended PSG
☐ Consumer preference
☐ Physical disability with inadequate carer attendance
☐ Suspected non-OSA sleep disorder
☐ Body Position verification is essential
☐ Unsuitable home environment

Please ensure the following box is ticked and the referring doctor details are completed. The sleep study cannot be booked without this information.

☐ I would like the Ramsey Sleep Centre to arrange an appointment for my patient with the reporting physician to discuss the result and arrange further management as needed.

Doctors Name: ..... Provider Number: .....

Address: .....

Signature: ..... Date: ....

OFFICE USE ONLY:

Sleep Study approved: ☐ Yes ☐ No Approved by: .....

Location: ..... Study Date: .....

PLEASE EMAIL THIS FORM DIRECTLY TO THE SLEEP CENTRE **E:** sleepcentre.VIC@ramsayhealth.com.au **P:** 1300 521 101

SLEEP CENTRE DIRECT REFERRAL FORM MR 055