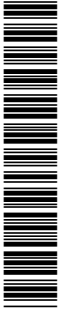


**SLEEP CENTRE DIRECT
REFERRAL FORM**

Unit Record Number: _____
 Family Name: _____
 Given Name(s): _____
 Date of Birth: _____ Sex: _____
 Doctor(s): _____
 (ATTACH PATIENT ID LABEL)

PATIENT DETAILS



WRP100120

BINDING MARGIN - DO NOT WRITE

SLEEP CENTRE DIRECT REFERRAL FORM

MR 055

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 Warrigal 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

Obesity: Waist circumference for Males >102cm or Females >88cm	If Yes, score
Snoring: Has your snoring ever bothered other people?	3
Apnoeas: Has anyone noticed that you stop breathing during your sleep?	3
50: Are you aged 50 or over?	2
	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting, inactive in a public place (eg. theatre or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL:				/24

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

- | | |
|--|---|
| <input type="checkbox"/> Intellectual disability or cognitive impairment | <input type="checkbox"/> Physical disability with inadequate carer attendance |
| <input type="checkbox"/> Significant relevant co-morbidities | <input type="checkbox"/> Suspected non-OSA sleep disorder |
| <input type="checkbox"/> Suspected parasomnia or seizure disorder | <input type="checkbox"/> Body Position verification is essential |
| <input type="checkbox"/> Failed or inconclusive unattended PSG | <input type="checkbox"/> Unsuitable home environment |
| <input type="checkbox"/> Consumer preference | |

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