Orana Mall Pharmacy

Send Referral Form to -
Email: nurseomp@lifepharmacygroup.com.au
Fax: 02 6884 6284

Sleep Test Referral

Ambulatory Home Sleep Test

Patient Information

Surname		**D.O.B.**		☐ **MALE** ☐ **FEMALE**	
Given Names					
Address				**Postcode**	
				Phone	
Medicare No.				**Private Health Insurance** ☐ **YES** ☐ **NO**	

Indications, Symptoms and Health Comorbidities

In order to meet Medicare requirements, patients should have a high probability of moderate to severe OSA using approved assessment tools. Please tick or write the scores below from the eligible questionnaires (refer over page for details):

Epworth Sleepiness Score ≥ 8 ☐ **AND** **OSA50 ≥ 5** ☐

OR

STOP-BANG ≥ 4 ☐

OR

BERLIN (tick if positive) ☐

Additional details: _____

Telehealth Consultation: ☐ **YES** ☐ **NO**

Referring Doctor

Date		**Provider No.**	
Name			
Address			
		Postcode	
Phone		**Fax**	
Email		**Signature**	

Report Preference: ☐ **Mail** ☐ **Fax** ☐ **Email**

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Epworth Sleepiness Questionnaire

How likely are you to doze off or fall asleep in the following situations, in contrast to sitting and reading just feeling tired? This refers to your recent/current way of life. Even if you have not done some of these things recently, try to determine how they would affect you.

Circle the response that best describes you:	**Never**	**Slight**	**Moderate**	**High**
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	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 lunch without alcohol	0	1	2	3
In a car as a driver stopped for a few minutes in traffic	0	1	2	3

OSA50

Obesity: Waist circumference (male > 102cm, female > 88cm)	+3	
Snoring: Has your snoring ever bothered other people?	+3	
Apnoea: Has anyone noticed that you stopped breathing during your sleep?	+2	
50: Are you aged 50 years or over?	+2	
TOTAL (5 points or more indicates moderate to high risk)		**_____/10**

STOP-BANG

Do you **s**nore loudly? Louder than talking or loud enough to be heard through closed doors?	+1	
Do you often feel **t**ired, fatigued, or sleepy during the daytime?	+1	
Has anyone **o**bserved you stop breathing or choking/gasping during sleep?	+1	
Do you have (or are you being treated for) high blood **p**ressure?	+1	
BMI > 35kg/m2	+1	
Age > 50 years	+1	
Neck circumference > 43cm (M) Neck circumference > 41cm (F)	+1	
Gender: Male?	+1	
TOTAL (4 points or more indicates moderate to high risk)		**_____/8**