REFERRAL FORM

Please send your referral to us by Fax: (02) 8252 2017

Our staff will contact the patient to book an appointment. Patients: Please bring this referral to your appointment.

Full name _____ DOB _____

Email _____ Phone / Mob _____ Commercial drivers licence ○ Yes ○ No

Request for a Referral *(Please mark appropriate options)*

- ○ **Home sleep study** - *This referral covers both a Home Sleep Study, and if required, sleep physician consultation*
- ○ **CPAP/APAP** trial for the treatment of sleep apnea
- ○ **Mandibular advancement** oral device for the treatment of snoring and sleep apnea
- ○ **CPAP therapy review** (pressure, compliance, mask review & full equipment check)
- ○ **Supply of DVA approved equipment and services**

Both OSA 50 AND ESS scores must be completed to qualify for a Medicare rebated Home Sleep Study (Medicare item 12250)

Both ESS and OSA-50 questionnaires must be completed

ESS Questionnaire - *Patient must **score 8** or more.*

How likely are you to doze off (fall asleep) in the following situations?

Use the following scale to choose the most appropriate answer:

0 - No chance
1 - Slight chance
2 - Moderate chance
3 - High chance

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

Total score: _____

OSA-50 Screening Questionnaire - *Patient must **score 5** or more.*

Waist circumference (Measure at the level of the umbilicus) Male > 102cm | Females > 88cm	○ Yes **(3 points)**
Has your snoring ever bothered other people?	○ Yes **(3 points)**
Has anyone noticed you stop breathing during your sleep?	○ Yes **(2 points)**
Are you aged 50 years or over?	○ Yes **(2 points)**

Total score: _____

Symptoms and medical conditions

- ○ Hypertension
- ○ Cardiac failure
- ○ Stroke / TIA
- ○ COPD
- ○ Other: _____
- ○ Overweight
- ○ Pacemaker
- ○ Type II Diabetes
- ○ Atrial fibrillation
- ○ Family history (OSA)
- ○ Clinical history *(optional, attach notes to this referral)*

For a referral to be valid, please ensure the following details are completed and SIGNED

Referring Dr. name _____ Practice name _____

Provider no. _____ Address _____

Email _____ Phone _____ Fax _____

Referring Dr. signature: _____ Referral date _____

○ Communication via secure e-messaging preferred

https://revitalisesleepclinic.com.au/