# REFERRAL FORM

Please send your referral to us by Email: kristy@revitalisesleepclinic.com.au

**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** - *$150 AUD Out of Pocket Fee*
- ○ **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)

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/