

**PATIENT DETAILS:**

Title: \_\_\_\_\_ Name: \_\_\_\_\_

Phone No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ Medicare No: \_\_\_\_\_

**REQUIRED:**

PLEASE CHOOSE OPTION 1 OR OPTION 2

**OPTION 1**

Physician consultation (referral includes sleep study if indicated)

No further information required. Go to Referring Doctor's details.

**OR**

**OPTION 2**

Diagnostic sleep study **without** physician review.

For Option 2, Medicare rules require that **A and B must be completed:**

**A.** Epworth Sleepiness Scale score of 8 or more

AND

**B.** OSA 50 score of 5 or more **OR** STOP-Bang score of 3 or more

(Scores on back)

**CLINICAL NOTES:**

\_\_\_\_\_  
\_\_\_\_\_

**LUNG FUNCTION TEST**

Detailed lung function test \_\_\_\_\_

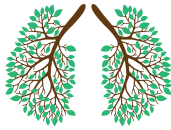
Six minute walk test \_\_\_\_\_

**REFERRING DOCTOR'S DETAILS:**

Name: \_\_\_\_\_ Practice: \_\_\_\_\_

Address: \_\_\_\_\_ Provider No: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## OSA 50 SCREENING QUESTIONNAIRE

<b>Obesity</b> Waist circumference: Male >102cm or Females >88cm	If yes, SCORE <b>3</b>
<b>Snoring</b> Has your snoring ever bothered other people?	<b>3</b>
<b>Apnoeas</b> Has anyone noticed that you stop breathing during your sleep?	<b>2</b>
<b>Age</b> Are you aged of 50 years or over?	<b>2</b>
<b>Total score</b>	<b>/10</b>

## STOP-BANG SLEEP APNOEA QUESTIONNAIRE

### STOP

Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)?  Yes  No

Do you often feel **TIRED**, fatigued, or sleepy during the daytime?  Yes  No

Has anyone **OBSERVED** you stop breathing during your sleep?  Yes  No

Do you have or are you being treated for high blood **PRESSURE**?  Yes  No

### BANG

**BMI** more than 35kg/m<sup>2</sup>  Yes  No

**AGE** over 50 years old?  Yes  No

**NECK** circumference > 16 inches (40cm)?  Yes  No

**GENDER:** Male?  Yes  No

### Total score

High risk of OSA: Yes 5 - 8  
Intermediate risk of OSA: Yes 3-4  
Low Risk of OSA: Yes 0 - 2

## EPWORTH SLEEPINESS SCALE

Use the following scale to choose the most appropriate number for each situation

- 0 = would never doze**
- 1 = slight chance of dozing**
- 2 = moderate chance of dozing**
- 3 = high chance of dozing**

It is important that you answer each question as best you can.

### Situation

Chance  
of dozing  
0 - 3

Sitting and reading

Watching TV

Sitting, inactive in a public place  
(e.g. a theatre or a meeting)

As a passenger in a car for an  
hour with 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 the traffic