SleepServices Australia Pty Ltd

Sleep Study Request

☎ 1300 867 533 | 🖨 1300 867 532 | ✉ bookings@sleepservices.com.au

First Name:______________ Surname:______________ Gender:______ D.O.B:__________

Address:______________ Suburb:__________ State:______ Postcode:______

Tel: ( )__________ Mobile:__________ Medicare/DVA No.:__________ Ref No.:______

☐ Private ☐ Concession ☐ Workers' Comp ☐ Pre-Employment/OHS ☐ Yearly OHS Assessment

TEST REQUIRED:

Sleep Study Type:
- ☐ Diagnostic
- ☐ MAS Review
- ☐ CPAP Review
- ☐ Provent Review
- ☐ Respiratory Signals Only

Other Services: (Head Office Only)
- ☐ Physician Consultation
- ☐ CPAP Trial
- ☐ Apnoea Guard Trial
- ☐ CPAP Equip. Review

Respiratory Function Test: (Head Office Only)
- ☐ Spirometry
- ☐ Gas Transfer (DCLO)
- ☐ Bronchial Challenge (Aridol)
- ☐ Lung Volume
- ☐ MIPS/MEPS

CLINICAL INFO:
- ☐ Snoring
- ☐ Daytime Lethargy/Sleepiness
- ☐ Nocturnal Gasping/Choking
- ☐ Witnessed Apnoeas
- ☐ Other__________
- ☐ Unrefreshing Sleep
- ☐ Insomnia
- ☐ Restless Legs

COMORBIDITIES:
- ☐ Atrial Fibrillation
- ☐ Stroke/TIA
- ☐ Hypertension
- ☐ Cardiac Failure
- ☐ Other__________
- ☐ Diabetes
- ☐ Depression
- ☐ COPD

DATE RESULTS REQUIRED:

☐ Standard ☐ Urgent ☐ Email ☐ Fax

COPY RESULTS TO :
(Full name of Doctor, Address and Contact details must be included):

REQUESTING DOCTOR CONTACT DETAILS MUST BE COMPLETED:
(PROVIDER NO., SURNAME AND INITIAL, ADDRESS, PHONE AND FAX)

__________ Doctor's Signature __________ Request Date

For a **Sleep Study Test** to be performed for your patient it is a Medicare requirement that the following questions **MUST** be answered:

Height ________ cms. Weight ________ Kgs. BMI ________ Neck Circumference ________ cms. Age ________

STOP-Bang Scoring Model

1	Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
2.	Tired: Do you often feel tired, fatigued, or sleepy during daytime?	Yes	No
3.	Observed: Has anyone observed you stop breathing during your sleep?	Yes	No
4.	Blood pressure: Do you have or are you being treated for high blood pressure?	Yes	No
5.	BMI: BMI more than 35 kg/m2?	Yes	No
6.	Age: Age over 50 years old?	Yes	No
7.	Neck circumference: Neck circumference greater than 40cm?	Yes	No
8.	Gender: Gender male?	Yes	No

***High risk* of OSA: answering yes to three or more items.** ***Low risk* of OSA: answering yes to less than three items.**