DIAGNOSTIC TESTS
REFERRAL FORM

Sleep and Respiratory Physicians
Dr Geoffrey Williams 408456W
Dr Csaba Varga 5724756K

QLD
Shop 3 Mantra Building
9 Buccaneer Drive
Urangan, QLD 4655
P 0741838777
E referrals@medisleep.net.au

NSW
Suites 7&8
70 River Street
Ballina NSW, 2478
P 0266862403
Fax 1800 004 841

SERVICE REQUESTED Referral Date: ____/____/_____

☐ CPAP Treatment Trial ☐ CPAP Treatment Review ☐ *Pulmonary Function Test
☐ Home Based Ambulatory Sleep Study ☐ Ambulatory Holter 24hr ECG Recording ☐ Spirometry
*PFT Ballina only

PATIENT DETAILS

Name: _____ *DOB:* ____/___/____ *Gender:* _____

Address: _____

Phone: _____ *Medicare:* _____ *exp:* _____ *Email:* _____

Height: _____ *cm* *Weight:* _____ *kg* *BMI:* _____

Sleep questionnaire:

		Office use only OSA50 ≥ 5	STOPBANG ≥ 4	Berlin
Do you snore loudly ?	☐	☐(3)	☐	◯
At least 3-4 times a week ?	☐			◯
Does your snoring bother other people ?	☐			◯
Has anyone noticed you stop breathing during sleep ?	☐	☐(2)	☐	
Does this happen at least 3-4 times a week ?	☐			◯
Do you fee tired / fatigued after your sleep 3-4 times a week ?	☐		☐	☐
When you wake do you feel tired or fatigued 3-4 times a week ?	☐			☐
Are you over 50 years of age ?	☐	☐(2)	☐	
Are you male ?	☐		☐	
Waist circumference: cm, BMI >30 ?	☐	☐(3)		Δ
What is your BMI ? >35	☐		☐	
Are you on blood pressure medication ?	☐		☐	Δ
		___	___	2 cats ≥ 2 Y/N

Epworth Sleepiness Scale questionnaire: *(Medicare subsidised Sleep Study, a patient MUST score 8 or more on the following)*

How likely are you to doze/nod in the following situations, in contrast to just feeling tired?

Situation	*Chance of dozing (0-3)*
Sitting and reading	☐0 ☐1 ☐2 ☐3
Watching television	☐0 ☐1 ☐2 ☐3
Sitting inactive in a public place, for example, a 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	☐0 ☐1 ☐2 ☐3
Sitting and talking to someone	☐0 ☐1 ☐2 ☐3
Sitting quietly after lunch (when you've had no alcohol)	☐0 ☐1 ☐2 ☐3
In a car, whilst stopped at traffic	☐0 ☐1 ☐2 ☐3

Total Score: _____

Use the following Scale to choose the most appropriate answer

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

REFERRING PRACTIONER

Doctor: _____ **Provider No:** _____

Practice Address: _____ **Phone:** _____

Signature: _____ **Date:** ___ / ___ / _____