QUEENSLAND SLEEP

ADULT STUDY ASSESSMENT REFERRAL

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Locations: Brisbane, Sunshine Coast, Cairns, Lismore, Rockhampton, Townsville

RACGP | CPD Education Provider 2020 22

Australasian Sleep Association

NATA

Accredited for compliance with ASA Standard for Sleep Disorders Services

Name _____ DOB _____

Address _____ Mobile _____

Complete referral / return via one of the following options:
Fax: 07 4728 6133 **Medical Objects:** search "Sleep Qld"

Test Requested _____

STEP 1 ☐ Diagnostic Sleep Investigation. *(Proceed to and complete 4,5,6,7 and 8).*

OR

STEP 2 ☐ CPAP Titration ☐ MAS/MRD Titration ☐ Body Position Modification Study

Sleep Physician consultation MUST be selected in addition to studies in STEP 2 and will only be booked if clinically indicated and with patient consent.

STEP 3 ☐ Sleep Physician Consultation *(Proceed to and complete step 8)*

STEP 4

OSA50 Questionnaire	**If "yes" circle**
Is waist circumference >102cm if male or >88cm if female?	3
Has the patient's snoring ever bothered other people?	3
Has anyone reported apneas during the patient's sleep?	2
Is the patient over 50 years of age?	2

Total _____

STEP 5

Epworth Sleepiness Scale	**(Rate 0-3 to indicate chance of dozing) 0-Unlikely 3-Likely**			
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Passenger in car trip	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting inactive in public (meeting or theatre)	0	1	2	3
Lying down in the afternoon when able	0	1	2	3
Sitting after lunch without alcohol	0	1	2	3
In a car stopped in traffic for a few minutes	0	1	2	3

Total _____

STEP 6 OSA50 must be ≥5 **AND** Epworth Sleepiness score must be ≥8 to meet criteria for a Medicare funded diagnostic sleep investigation. If the criteria are not met,
Refer to Step 3 and request a sleep physician consult. ☐ **OSA50 Score** ☐ **ESS Score**

STEP 7 **Does the patient have any of the following** *(please tick all that apply)*

☐ Unexplained sleepiness (adequate sleep hygiene and environment)
☐ Active cardiac disease / arrhythmia
☐ Possible movement disorder (no RLS).
☐ Possible sleep hypoventilation
☐ Possible parasomnia
☐ Acromegaly or thyroid disease
☐ Possible central sleep apnea
☐ Neurological issues
☐ Unsuitable home environment (Note Reason)

Reasons: _____

STEP 8 Referring Doctor's Details:

Name: _____

Address: _____ Provider no: _____

Signature: _____ Date: _____