Queensland Sleep

QUEENSLAND SLEEP

ADULT STUDY ASSESSMENT REFERRAL

Tel: 1800 717 566 E: sa@qsdu.com.au
Locations: Brisbane, Cairns, Lismore, Rockhampton, Townsville

RACGP | CPD Education Provider 2020 22

Australasian Sleep Association NATA

Name ____________________ **DOB** ____________________

Address ____________________ **Mobile** ____________________

Complete referral / return via one of the following options:
Fax: 07 3217 2523 **Medical Objects:** search "sleep"
Best Practice: word processor template listed under "sleep"

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 seletec 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-Unlikly 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 Score 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)

Reason: ____________________

STEP 8 Referring Doctor's Details:

Name: ____________________

Address: ____________________ Provider no: ____________________

Signature: ____________________ Date: