WA SLEEP

ADULT STUDY ASSESSMENT REFERRAL

Tel: 1300 65 1234 E: reception@wasleep.com.au
HEAD OFFICE: SJOG Level 1, Suite 102, 25 McCourt St, Subiaco WA 6008

Name ______________________ Email ______________________

D.O.B. __________ Medicare/Ref#__________ Pvt. Health Fund/No. __________

Address ______________________ Mobile __________

Return referral via: 1300 65 1234 or email at reception@wasleep.com.au

Test Requested (Please tick and/or circle) Location: ☐ Subiaco ☐ Murdoch ☐ Mandurah ☐ Kalgoorlie ☐ Geraldton

STEP 1

- ☐ Diagnostic Sleep Investigation + Management **(Home-based / In Lab)**
- ☐ CPAP titration, Bilevel titration, NSR, MAS, or Split Study
- ☐ DVA Approved Equipment Supply for Eligible Patients
- ☐ MSLT/MWT Study
- ☐ CPAP trial/support
- ☐ Others ______________________
- ☐ TcCO2
- ☐ Urgent

Bilevel IPAP: ______
EPAP: ______

STEP 2

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 apnoeas during the patient's sleep?	2
Is the patient over 50 years of age?	2

Total ______

STEP 3

Epworth Sleepiness Scale (Rate 0-3 to indicate chance of dozing) 0-Unlikely 3-Likely

Situation				
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 4 **Does the patient have any of the following**

- ☐ 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 apnoea
- ☐ Neurological issues
- ☐ Unsuitable home environment
- ☐ BMI > 40

Clinical Details: ______________________

STEP 5 Referring Doctor Details:

Name: ______________________ Clinic/Practice Name: ______________________

Practice/Address: ______________________ Provider no: __________

Signature: ______________________ Date: __________

Please send copies to ______________________