RESPIRATORY AND SLEEP MEDICINE CLINICAL REQUEST FORM

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We will contact the patient for an appointment

LABEL MUST BE AFFIXED IF HOSPITAL INPATIENT

PATIENT NAME | DATE OF BIRTH

PHONE NUMBER | GENDER

REQUESTED CONSULTATIONS AND INVESTIGATIONS - tick all required

- □ **Respiratory physician consultation**
- □ **Sleep physician consultation**
- □ Respiratory AND sleep consultation

* Indicates requires physician consultation

- □ **Complex lung function (RFTs)**
- □ Flow volume loops + FeNO
- □ Cardiopulmonary exercise test*
- □ Bronchoscopy* □ EBUS*

- □ **Diagnostic sleep study** □ Home □ Lab*
- □ CPAP titration* □ CPAP review*
- □Autoset CPAP trial [□ with SpO2]
- □ Mandibular advancement splint trial*

COMPLETE EPWORTH AND STOP-BANG IF REFERRING FOR DIAGNOSTIC SLEEP STUDY WITHOUT SLEEP PHYSICIAN REVIEW

EPWORTH SLEEPINESS SCALE (ESS)

How likely is the patient to doze off or fall asleep in the following situations:

0 = would never fall asleep
1 = slight chance of falling asleep
2 = moderate chance of falling asleep
3 = high chance of falling asleep

Sitting and reading	___ /3
Watching TV	___ /3
Sitting inactive in a public place (theatre, meeting, etc)	___ /3
As a passenger in a car for an hour without a break	___ /3
In a car, while stopped for a few minutes in traffic	___ /3
Lying down to rest in the afternoon	___ /3
Sitting quietly after lunch without alcohol	___ /3
Sitting and talking to someone	___ /3
TOTAL SCORE (≥ 8 required for PSG referral; > 10 abnormal)	__ /24

STOP-BANG QUESTIONNAIRE FOR RISK OF OSA

Assign 1 point for each 'Yes' response:

Does the patient **S**nore loudly (louder than talking or loud enough to be heard through closed doors)?	___ /1
Does the patient often feel **T**ired, fatigued, or sleepy during the daytime?	___ /1
Has anyone **O**bserved the patient stop breathing during their sleep?	___ /1
Is the patient being treated for high blood **P**ressure?	___ /1
Is the **B**ody Mass Index more than 35 kg/m^2?	___ /1
Is the patient **A**ged over 50 years old?	___ /1
Is the patient's **N**eck circumference greater than 43 cm for males or > 41 cm for females?	___ /1
Is the patient of male **G**ender?	___ /1
TOTAL SCORE (≥ 4 high risk - required for direct PSG referral)	___ /8

ELIGIBILITY FOR DIRECT REFERRAL MEDICARE SUBSIDISED DIAGNOSTIC SLEEP STUDY

- □ **Yes** - Patient has qualified if ESS ≥ 8 AND STOP-BANG ≥ 4. Please fax referral to 07 3844 2441. We will contact the patient.
- □ **No** - OPTIONS
  - □ Sleep physician consultation - recommended as >50% of patients with OSA do not meet new Medicare criteria
  - □ Non-Medicare diagnostic sleep study - please fax referral and we will contact patient with options

SYMPTOMS

- □ Snoring
- □ Headaches
- □ Witnessed apnoeas/gasping/choking
- □ Restless sleep
- □ Daytime lethargy/sleepiness
- □ Irritability
- □ Cognitive/memory issues
- □ Insomnia

PATIENT PRESENTATION

*Indicates an attended (in-lab) study may be required

- □ Cardiac co-morbidity*
- □ Neurologic disease*
- □ Respiratory disease*
- □ Hypothyroidism*
- □ Neuromuscular disease*
- □ Previous failed study*
- □ Patient prefers lab study*
- □ Insomnia*
- □ Suspected additional sleep disorder*
- □ Unsuitable for home environment*
- □ Suspected central sleep apnoea*
- □ Hypertension
- □ Type II diabetes mellitus
- □ Nocturia
- □ Body position required*
- □ Suspected narcolepsy*

CLINICAL NOTES

□ Commercial licence holder/railway worker/pilot □ Privately insured □ Summary attached

REFERRING DOCTOR DETAILS

Results will be sent via Medical Objects by default. If this is not possible, results will be sent by post to the address below.

Name: _____ Signature: _____ Date: _____

Provider Number: _____ Address: _____

cc: _____