

## Patient Details

Name:	<input type="text"/>	Telephone 1:	<input type="text"/>
Address:	<input type="text"/>	Telephone 2:	<input type="text"/>
City:	<input type="text"/>	State:	<input type="text"/>
	Postcode:	<input type="text"/>	Email:
Medicare No/DVA No:	<input type="text"/>	Expiry:	<input type="text"/>
	DOB:	<input type="text"/>	Healthfund:
		<input type="text"/>	<input type="text"/>

## Referring Doctor Details \*(all referrals must be signed and dated for medical purposes)

Stamp:	<input type="text"/>	Name:	<input type="text"/>
		Provider No:	<input type="text"/>
		Telephone:	<input type="text"/>
		Fax:	<input type="text"/>
		Address:	<input type="text"/>
Signature*:	<input type="text"/>	Suburb:	<input type="text"/>
Date:	<input type="text"/>	Postcode:	<input type="text"/>

## Service Requested

Diagnostic Sleep Study - to confirm diagnosis of Obstructive Sleep Apnea and specialist consultation where deemed appropriate by the sleep physician

Clinical history:

### Sleep Physician Consultation:

## Medical Co-Morbidities (Please complete as appropriate)

Height (cm) = <input type="text"/>	Type 2 diabetes	AF	Cardiac failure	Stroke/TIA	COPD	Previous sleep study:	
Weight (kg) = <input type="text"/>	Other Co-Morbidities:					Yes	No
BMI (kg/m <sup>2</sup> ) = <input type="text"/>	<input type="text"/>					Date:	<input type="text"/>
	<input type="text"/>						

## Medicare Guidelines Criteria (STOPBang OR OSA50 AND Epworth Sleepiness Scale Questionnaire)

### STOP-Bang<sup>1</sup>: A score of $\geq 3$

<b>S</b> – Does the patient SNORE loudly?		
<b>T</b> – Does the patient often feel TIRED, fatigued or sleep during daytime?		
<b>O</b> – Has anyone OBSERVED the patient stop breathing during sleep?		
<b>P</b> – Does the patient have or is the patient being treated for high blood PRESSURE?		
<b>B</b> – Does the patient have a BMI more than 35?		
<b>A</b> – AGE over 50 years old		
<b>N</b> – NECK circumference (shirt size) more than 40cm / 16 inches		
<b>G</b> – Is the patient a MALE?		
Each question is 1 score	<b>TOTAL score</b>	<input type="text"/>

### OSA50<sup>2</sup>: A score of $\geq 5$

<b>O</b> Obesity (3)	Waist circumference: Male >102cm or Female >88cm
<b>S</b> Snoring (3)	Has your patient's snoring ever bothered other people?
<b>A</b> Apnea (2)	Has anyone noticed that your patient stopped breathing during sleep?
<b>50</b> (2)	Is your patient aged 50 years or over?
( ) = score	<b>TOTAL score</b>
	<input type="text"/>

or

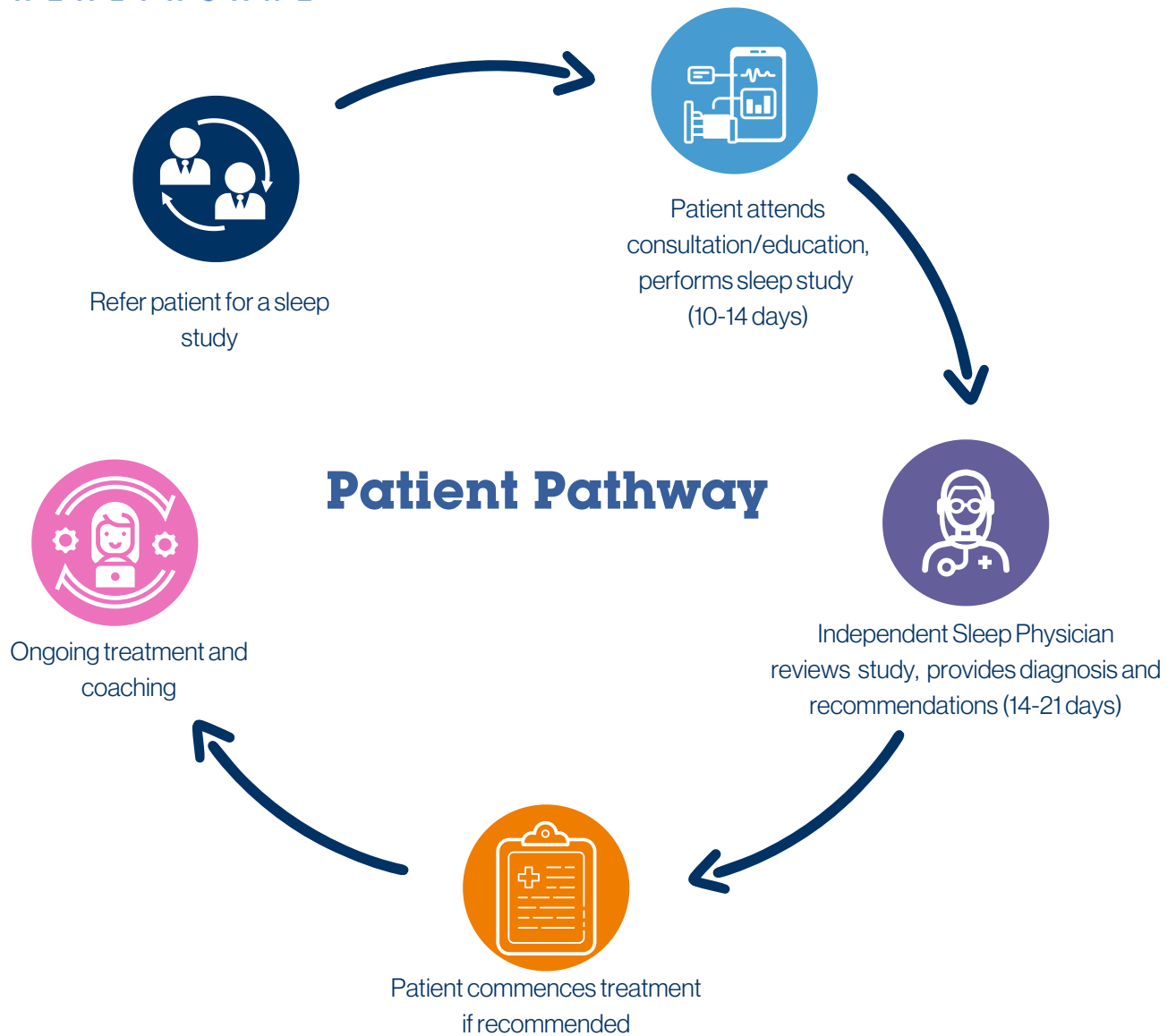
and

### Epworth Sleepiness Scale<sup>3</sup> Questionnaire: A score of $\geq 8$

Scenario	Tick one score for each scenario			
	0	1	2	3
Sitting and reading				
Watching television				
Sitting inactive in a public place (eg. theatre or meeting)				
As a passenger in a car for an hour without a break				
Lying down in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				
<b>TOTAL SCORE (add up total responses)</b>				<input type="text"/>

For the 8 situations in the table below, how likely is the patient to doze off or fall asleep, in contrast to feeling just tired? Even if the patient has not done some of these things recently, ask them how the situations *would have* affected them. Use the following scale to choose the most appropriate number for each situation:  
 0 = Would never doze  
 1 = slight chance of dozing  
 2 = moderate chance of dozing  
 3 = high chance of dozing  
 Then total the scores.

<sup>1</sup> Chung F et al Anaesthesiology 2008 & Br J Anaesth 2012; <sup>2</sup> Chai-Coetzer CL et al Thorax 2011; <sup>3</sup> Johns M Sleep 1991







**ON THE DAY OF THE SLEEP STUDY**

- No nail polish or acrylic fingernails
- A credit card may be required to cover a fully refundable security deposit for the test device



FAQs

**OVER 120 LOCATIONS ACROSS AUSTRALIA**

-  1300 36 02 02
-  1800 270 779
-  [sleepstudy@airliquide.com](mailto:sleepstudy@airliquide.com)
-  <https://sleepsolutionsaustralia.com>



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