Sleep Dynamics
DYNAMIC HEALTH AUSTRALIA

Referral to Sleep Specialist

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Patient Information

Patient Name:	DOB:	Telephone:	Mobile:
If under 18 Parent Name:	Email:		
Address:			
Gender: / Health Fund:	Medicare No/DVA No:		

Request

☐ Consultation ☐ Overnight Oximetry ☐ CPAP/APAP Treatment Trial
☐ Consultation/ PSG Sleep Study ☐ Lab Based PSG / Titration ☐ Bi Level Trial
☐ MSLT ☐ MWT

Medical Co-Morbidities (Please complete as Appropriate)

Height: cm	Weight: kg	Diabetes ☐ Excessive Daytime Fatigue ☐ COPD ☐	AF ☐ Cardiac ☐
BMI:		Stroke/TIA ☐ Depression/Anxiety ☐ Gastric Reflux ☐	Restlessness ☐
Prior Sleep Study Y/N Date:		Snoring ☐ Choking/Gasping ☐ Witnessed Apneas ☐	Restless Legs ☐
Other:			

Epworth Sleepiness Scale Questionnaire to be completed for an adult or child

For the 8 situations in the table below, how likely is the patient to doze off or fall asleep. 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.

Situation	Score
Sitting and reading	
Watching Television or Movie or Other Screens	
Sitting inactive in a public place (eg school, cinema, meeting or waiting room)	
Passenger in a car or bus for > 30-60mins without a break	
Lying down to rest or nap in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car stopped for a few minutes in traffic	
TOTAL ESS SCORE:	**/24**

Medicare guidelines for adults require careful patient screening prior to determining the most appropriate test/ consultation. Direct testing may be appropriate if the patient has a high probability for moderate-severe OSA: Epworth Sleepiness Scale of 8 or more and a score of 3 or more on a validated STOP BANG questionnaire

STOP BANG Questionnaire (Please complete for adult only)

S – Does the patient SNORE loudly? ☐	B – Does the patient have a BMI higher than 35? ☐
T – Does the patient often feel TIRED, fatigued or Sleepy during the day? ☐	A -AGE over 50 years old ☐
O – Has anyone OBSERVED the patient stop breathing in their sleep? ☐	N – NECK Circumference (shirt size) more than 40 cm/16 inches ☐
P – Does the patient have or is the patient being treated for high blood PRESSURE? ☐	G – Is the patient a MALE? ☐ **TOTAL SCORE: /8**

Referring Physician Details

Referring Physician:	Practice:
Provider Number:	Address:
Signature:	Phone:
CC: Date:	Email: