

Referral to Sleep Specialist

☐ Dr Krishan Gupta Sleep and Respiratory Physician	OFFICE: 02 6527 7886
	FAX: 02 6527 7887
EMAIL: referrals@sleepdynamics.com.au	17 York Street Taree NSW 2430

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	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
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	

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:

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Sleep Lab Clinic and Screening Centre Locations

Gateshead Singleton Toronto Maitland Cessnock Taree Forster