Comprehensive Sleep Testing and Treatment.

The CPAP Room

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133 Gloucester Ave Belair 5052

PATIENT DETAILS

Name: _____ Date of Birth: _____

Address: _____ Sex: _____

_____

Home Phone: _____ Mobile: _____

Email: _____ Medicare No _____

PATIENT PRESENTATION *(Please Indicate)*

- ☐ ? Obstructive Sleep Apnoea (OSA)
- ☐ Hypertension
- ☐ Excessive Daytime Sleepiness
- ☐ Diabetes Type 2
- ☐ Congestive Heart Failure
- ☐ BMI >30
- ☐ Abnormal activity during sleep
- ☐ Snoring
- ☐ Arrhythmia
- ☐ Insomnia
- ☐ Nocturia
- ☐ Narcolepsy
- ☐ Commercial driver
- ☐ Other

CLINICAL NOTES:

_____

_____

_____

REFERRING DOCTOR DETAILS *(Including Provider No.)*

SLEEP INVESTIGATION REQUIRED

- ☐ Home Sleep Study
- ☐ CPAP Pressure Review
- ☐ Sleep Study with Dental Device
- ☐ Consultation Only

FOLLOW UP

- ☐ Consultation and ongoing management (recommended) *

Nominated Specialist **Dr Carissa Yap**

OR

- ☐ No specialist consultation required

CPAP CLINIC SERVICE REQUIRED

Commence CPAP trial:

- ☐ Fixed pressure _____cmH20
- ☐ Auto pressure range _____cmH20
- ☐ As per CPAP Titration report recommendations
- ☐ **Mask:** Make: _____ Size: _____
- ☐ Chinstrap
- ☐ As per CPAP Titration report recommendations
- ☐ **Review CPAP therapy and equipment**
- ☐ **CPAP download**

Signature: **Date:**

Medicare subsidised Sleep Studies referred directly from medical practitioners, require the patient to be assessed as having a high probability of symptomatic, moderate to severe Obstructive Sleep Apnoea. The Sleep Physician assesses this criteria with an **ESS** questionnaire score **of 8 or above** and also a **STOPBANG** questionnaire **of 4 or above.**

Patients with referrals that **do not meet the criteria** will require, and be offered an appointment with the Sleep Physician.

Patients with **incomplete or inconclusive referrals** will be contacted by a sleep technician for further information.

ESS Questionnaire

How likely are you to doze off in these situations? Even if you haven't been in these situations recently, imagine how they might affect you.

How to score

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Sitting and reading	.....
Watching TV	.....
Sitting inactive in a public place	.....
As a passenger in a car without a break	.....
Lying down to rest in the afternoon when circumstances permitted	.....
Sitting and talking to someone	.....
Sitting quietly after lunch without alcohol	.....
In a car, while stopped for a few minutes in traffic	.....
Total Score	.....

STOP BANG Questionnaire

Tick if YES

- Do you **Snore** loudly? (louder than talking or loud enough to be heard through closed doors) ☐
- Do you often feel **Tired** fatigued, or sleepy during daytime? ☐
- Has anyone **Observed** you stop breathing during your sleep? ☐
- Do you have or are you being treated for high Blood **Pressure**? ☐
- **BMI** more than 35 kg/m2 ☐
- **AGE** over 50 years ☐
- **Neck** circumference > 40cm ☐
- **Gender** Male ☐

Total Score (tick = 1) .....

Email referral to the cpaproom@gmail.com

Thank you for your referral