

# Comprehensive Sleep Testing and Treatment

Phone 0416 632 699

Fax 8125 3883

thecaproom@gmail.com

2/229 Main Road BLACKWOOD 5051



The CPAP Room

## PATIENT DETAILS

Name \_\_\_\_\_

Address \_\_\_\_\_

D.O.B \_\_\_\_\_ Sex \_\_\_\_\_

Ph \_\_\_\_\_ Medicare # \_\_\_\_\_

email \_\_\_\_\_

## PATIENT PRESENTATION

- |   |  |
|---|--|
| <input type="checkbox"/> ? Obstructive Sleep Apnoea (OSA) | <input type="checkbox"/> Snoring           |
| <input type="checkbox"/> Hypertension                     | <input type="checkbox"/> Arrhythmia        |
| <input type="checkbox"/> Excessive Daytime Sleepiness     | <input type="checkbox"/> Insomnia          |
| <input type="checkbox"/> Diabetes Type 2                  | <input type="checkbox"/> Nocturia          |
| <input type="checkbox"/> Congestive Heart Failure         | <input type="checkbox"/> Narcolepsy        |
| <input type="checkbox"/> BMI >30                          | <input type="checkbox"/> Commercial driver |
| <input type="checkbox"/> Abnormal activity during sleep   | <input type="checkbox"/> Other             |

## CLINICAL NOTES:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## REFERRING DOCTOR DETAILS

(Including Provider No.)

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	.....
<b>Total Score</b>	.....

## STOP BANG Questionnaire

Tick if YES

- |   |                          |
|---|--------------------------|
| Do you <b>Snore</b> loudly? (louder than talking or loud enough to be heard through closed doors) | <input type="checkbox"/> |
| Do you often feel <b>Tired</b> fatigued, or sleepy during daytime?                                | <input type="checkbox"/> |
| Has anyone <b>Observed</b> you stop breathing during your sleep?                                  | <input type="checkbox"/> |
| Do you have or are you being treated for high Blood <b>Pressure</b> ?                             | <input type="checkbox"/> |
| <b>BMI</b> more than 35 kg/m <sup>2</sup>   | <input type="checkbox"/> |
| <b>AGE</b> over 50 years  | <input type="checkbox"/> |
| <b>Neck</b> circumference > 40cm  | <input type="checkbox"/> |
| <b>Gender</b> Male  | <input type="checkbox"/> |
| <b>Total Score</b> (tick = 1)   | .....                    |