Referral Form

Please send your referral to our Head Office via fax or email.
Call: 08 8344 6667 Fax: 08 8344 6669
Email: clmwalkerville@clmsleep.com
We will contact your patient to book an appointment.

Patient Details

First name: ..... Last name: ..... Gender: Female / Male

Address: .....

Telephone: *(Primary)* ..... *(Alternate)* ..... D.O.B: .....

Medicare Number: ..... Height: ..... cm Weight: ..... kg BMI: ..... Neck Circ: ..... cm

Private Hospital Cover? *Please circle* Yes / No

Driver's License Type *(if applicable): Please circle* Light / Heavy

Sleep Study Service(s) Required (PLS COMPLETE MEDICARE ELIGIBILITY CRITERIA OVERLEAF)

Please tick all applicable boxes.

- ☐ Home-based Sleep Study – *For suspected sleep apnoea*
  - ☐ *Pls circle:* Assess PAP/ MAS/ Positional therapy
- ☐ Hospital-based Sleep Study – *For suspected sleep disorders such as complex sleep apnoea, insomnia, RLS/PLMD or narcolepsy*
  - ☐ *Pls circle:* Assess PAP/ MAS/ Positional therapy
- ☐ Sleep Physician Consultation – *Patient review by a Physician on CLM Sleep's panel*

Other services Required

- ☐ PAP Trial / Review
- ☐ Oximetry assessment with PAP therapy
- ☐ Driving Simulation test
- ☐ Positional Therapy
- ☐ Sleep Hygiene Assessment
- ☐ Home Medication review assessment
- ☐ TCA – Diabetes/Asthma education, Dietitian assessment
- ☐ Naturopathy

Relevant Medical Condition(s) *(Please tick all applicable boxes)*

- ☐ Atrial Fibrillation
- ☐ CCF/IHD
- ☐ COPD/Respiratory Failure
- ☐ Parkinson's Disease
- ☐ Epilepsy
- ☐ CVA/TIA
- ☐ Others .....

Communicable diseases *(if applicable)*: .....

Disability *(if applicable)*: .....

Referring Doctor

☐ GP ☐ Dentist *Name:* .....

☐ Physician *Specialty:* .....

Name: .....

Provider No.: .....

Address: .....

Telephone: .....

Signature: .....

Date: .....

Sleep Physician

Name: .....

Provider No.: .....

Address: .....

Telephone: .....

Signature: .....

Date: .....

How would you like to receive the report for patient review?

☐ Email: .....

☐ Fax: ..... ☐ Hard Copy

To determine Eligibility for Medicare Subsidised Sleep Study, please ensure the questionnaires on both sections behind this page are completed.

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SECTION 1 - *Please complete the ESS with your patient.*

The Epworth Sleepiness Scale (ESS) How likely are you to doze off in these situations?	**Never** (0)	**Slight** (1)	**Moderate** (2)	**High** (3)
Sitting and reading				
Watching television				
Sitting inactive in a public place (e.g. a theatre or meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				
TOTAL SCORE				OUT OF 24

DID YOUR PATIENT SCORE ≥ **8**?

YES – Please proceed to Section 2 to determine the Medicare eligibility of a Sleep Study

NO – Patient does not meet the Medicare criteria for a Sleep Study.
Please fax this referral to us for a Sleep Physician consultation.

SECTION 2 - *Please complete STOP-BANG Questionnaire or OSA 50 Screening Questionnaire with your patient.*

STOP-BANG Questionnaire	**YES**	**NO**
Do you snore loudly?		
Do you often feel tired, fatigued, or sleepy during the daytime?		
Has anyone observed you stop breathing during your sleep?		
Do you have or are you being treated for high blood pressure?		
Are you obese/very overweight – BMI more than 35 kg/m^2?		
Age over 50 years old?		
Neck circumference greater than: 43cm *(male)* or 41cm *(female)*		
Are you male?		
TOTAL SCORE (1 point for each YES)		OUT OF 8

Total Score must be ≥ 4 to meet Medicare criteria.

OR

OSA 50 Screening Questionnaire	**If YES, score**
Waist circumference: Male > 102cm Females > 88cm	3
Has your snoring ever bothered other people?	3
Has anyone noticed you stop breathing during your sleep?	2
Are you aged 50 years or over?	2
TOTAL SCORE	OUT OF 10

Total Score must be ≥ 5 to meet Medicare criteria.

PATIENT ELIGIBILITY - *Please tick accordingly*

Epworth Sleepiness Scale
Patient must score 8 or more

+

STOP-BANG or OSA 50
Patient must score ≥4 or ≥5

=

Patient is eligible

	YES my patient has high suspicion of Sleep Apnoea and meets the Medicare requirements for a Medicare Subsidised Sleep Study. Please proceed to facilitate the Sleep study by a supervising Sleep Physician.
	NO my patient does not meet Medicare requirements for a Medicare Subsidised Sleep Study. Please arrange for a Sleep Physician consultation to determine the necessity for a Sleep Study for my patient.

Please fax or email this referral to the contact details provided. Upon receiving this referral, we will contact the patient to organise the service(s) listed and you will receive a full report on the outcome.