REFERRAL FORM FOR SLEEP PHYSICIAN TO REVIEW

mySleep Formerly ResSleep

Please send your referral to us by Fax: 1300 605 705 or Email: admin@mysleep.com.au or Medical Objects: mySleep
Our staff will contact the patient to book an appointment within 48 hours.

★ **Patient name** ..... D.O.B. .....
Email ..... ★ **Phone** .....

★ *Indicates essential information required*

DVA Gold Card: .....
Commercial Driver: ◯ YES ◯ NO
NDIS patient: ◯ YES ◯ NO
QHealth patient: ◯ YES ◯ NO

SERVICE REQUIRED

1

☑ **Home Sleep Study** *Complete Section 2 and Section 3 to assess if your patient is eligible to be Medicare Bulk Billed.*

ESS QUESTIONNAIRE (Mandatory)

2

How likely are you to doze or fall asleep in the following situations?:

Sitting and reading	◯ 0	◯ 1	◯ 2	◯ 3
Watching television	◯ 0	◯ 1	◯ 2	◯ 3
Sitting inactive, in a public space	◯ 0	◯ 1	◯ 2	◯ 3
Lying down to rest in the afternoon when circumstances permit	◯ 0	◯ 1	◯ 2	◯ 3
Sitting and talking to someone	◯ 0	◯ 1	◯ 2	◯ 3
Sitting quietly after a lunch without alcohol	◯ 0	◯ 1	◯ 2	◯ 3
As a passenger in a car for an hour without a break	◯ 0	◯ 1	◯ 2	◯ 3
In a car, while stopped for a few minutes in traffic	◯ 0	◯ 1	◯ 2	◯ 3
MEDICARE ELIGIBILITY IS = ≥8		TOTAL		/ 24

Use the following scale to choose the most appropriate answer:

0 - No chance
1 - Slight chance
2 - Moderate chance
3 - High chance

If patient has ≥8 on ESS **CHOOSE EITHER** OSA50 or STOPBANG

*(If patient has ESS < 8 **do NOT continue** - send the referral to us for assessment of other options)*

OSA50 QUESTIONNAIRE

3

Obesity	Is your waist* circumference over 102cm (M) or over 88cm (F)?	◯ **Yes** (+3) ◯ **No**
Snore	Has your snoring ever bothered people?	◯ **Yes** (+3) ◯ **No**
Apnea	Has anyone noticed that you stop breathing during your sleep?	◯ **Yes** (+2) ◯ **No**
50	You are aged 50 years or over?	◯ **Yes** (+2) ◯ **No**
MEDICARE ELIGIBILITY = ≥5	TOTAL	/ 10

** Waist measurement to be measured at the level of the umbilicus*
*** Measured around Adams Apple*

OR

STOPBANG QUESTIONNAIRE

Do you **S**nore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?	◯ **Yes** (+1) ◯ **No**
Do you often feel **T**ired, fatigued, or sleepy during the day (such as falling asleep during driving or talking to someone)?	◯ **Yes** (+1) ◯ **No**
Has anyone **O**bserved you stop breathing or choking/gasping during your sleep?	◯ **Yes** (+1) ◯ **No**
Do you have or are you being treated for high blood **P**ressure?	◯ **Yes** (+1) ◯ **No**
Is your **B**ody mass index more than 35kg/m2?	◯ **Yes** (+1) ◯ **No**
Are you **A**ged older than 50?	◯ **Yes** (+1) ◯ **No**
Is your **N**eck size large: Is your shirt collar 43cm or larger (M)** ? or 41cm or larger (F)?	◯ **Yes** (+1) ◯ **No**
Is your **G**ender male?	◯ **Yes** (+1) ◯ **No**
MEDICARE ELIGIBILITY = ≥3	YES TOTAL / 8

CONTRAINDICATIONS (Mandatory)

4

Does your patient have a physical disability with inadequate carer attendance, intellectual disability or cognitive impairment or has an unsuitable home environment?	◯ **Yes** ◯ **No**
Does your patient have neuromuscular disease, heart failure or advanced/suspected respiratory disease, suspected parasomnia or seizure disorder?	◯ **Yes** ◯ **No**
Has the patient had a previously failed or inconclusive home sleep study?	◯ **Yes** ◯ **No**

OTHER REFERRAL REASONS (Optional)

5

◯ Type II Diabetes ◯ Depression ◯ Stroke / TIA ◯ Insomnia ◯ Cardiac Arrhythmia
◯ Family history (OSA) ◯ Morning headaches ◯ Daytime sleepiness ◯ Hypertension ◯ Cardiovascular Disease

Other *(Relevant Health History - Optional, attach notes to this referral)*: .....

FOR THIS REFERRAL TO BE VALID, PLEASE ENSURE THE FOLLOWING DETAILS ARE COMPLETED:

★ **Referring Dr. Name:** ..... Phone: ..... Fax: .....
Provider Number: ..... Email: .....
Practice Name: .....
Address: .....

★ **Referral Date:** .....
★ **Signature:** .....

★ *Indicates essential information required*

◯ **Manage Patient Independently** (discussing the patient's sleep study results and treatment will be the responsibility of the GP or an alternative health professional)

The assessment and appropriateness of home studies directly requested by GP's are overseen by a supervising Sleep Physician.
Based on these assessments and the study findings, certain complex patients may require a Sleep Physician Consultation. This can be arranged by having rapid access to independent Local Sleep & Respiratory Physicians in Brisbane.
Medicare recommends a patient is seen by a health professional prior to treatment, please recall every patient and send a referral indicating treatment pathway required.
To book in or for more information or clarification on referring patients please contact your dedicated local Representative or call us on 1300 605 700

Upper Mt Gravatt 1722 Logan Rd QLD 4122
Greenslopes 496 Logan Rd QLD 4120
North Lakes 1/100 Flinders Parade QLD 4509
Chermside 960 Gympie Rd QLD 4032
Warana 1 Main Dr QLD 4575