QUEENSLAND SLEEP

ADULT STUDY ASSESSMENT REFERRAL

Tel: 1800 717 566 E: sa@qsdu.com.au
Locations: Brisbane, Cairns, Lismore, Rockhampton,
Sunshine Coast, Townsville, Bundaberg

RACGP | CPD Education Provider 2020 22

Australasian Sleep Association

NATA

Accredited for compliance with ASA Standard for Sleep Disorders Services

Name _____ DOB _____

Address _____ Mobile _____

Return referral via: Fax 07 3217 2523 or Medical Objects by searching sleep

Test Requested _____

Step 1 **Select Test**

- ☐ Diagnostic Sleep Investigation + Sleep Physician Consultation
- ☐ CPAP Titration + Sleep Physician Consultation
- ☐ DVA Approved Equipment Supply for Eligible Patients
- ☐ Sleep Physician Consultation Only - No Testing Requested

Consultations will only be booked if MBS criteria aren't met.

Step 2 **OSA50 Questionnaire** **If "yes" circle**

Is waist circumference >102cm if male or >88cm if female?	3
Has the patient's snoring ever bothered other people?	3
Has anyone reported apneas during the patient's sleep?	2
Is the patient over 50 years of age?	2

Total _____

Step 3 **Epworth Sleepiness Scale** **(Rate 0-3 to indicate chance of dozing)**

	0-Unlikely			3-Likely
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Passenger in a car trip	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting inactive in public (meeting or theatre)	0	1	2	3
Lying down in the afternoon when able	0	1	2	3
Sitting after lunch without alcohol	0	1	2	3
In a car stopped in traffic for a few minutes	0	1	2	3

Total _____

To be subsidised by Medicare Epworth score must be ≥ 8 and OSA50 must be ≥ 5

Step 4 **Patient Presentation - Please Select**

- ☐ Unexplained sleepiness (adequate sleep hygiene and environment)
- ☐ Active cardiac disease / arrhythmia
- ☐ Possible movement disorder (no RLS).
- ☐ Possible sleep hypoventilation
- ☐ Possible parasomnia
- ☐ Acromegaly or thyroid disease
- ☐ Possible central sleep apnea
- ☐ Neurological issues
- ☐ Unsuitable home environment

Clinical Details:

Step 5 Referring Doctor's Details:

Name: _____

Address: _____ Provider no: _____

Signature: _____ Date: _____