# QUEENSLAND SLEEP

Adult Study Assessment Referral

Tel: 1300 559 116 E: sa@qsdu.com.au

**Locations: Brisbane, Cairns, Lismore, Rockhampton, Townsville**

Accredited for compliance with ASA Standard for Sleep Disorders Services

Name _____ DOB _____

Address _____ Mobile _____

**Complete referral / return via one of the following options:**

**Fax :** 07 3217 2523 **Medical Objects:** search "sleep" **Best Practice:** word processor template listed under "sleep"

**Tests Requested** _____

**STEP 1** ☐ Diagnostic Sleep Investigation. (Proceed to and complete steps 4,5,6,7 and 8).

OR

**STEP 2** ☐ CPAP Titration ☐ MAS/MRD Titration ☐ Body Position Modification Study

Sleep Physician consultation MUST be selected in addition to studies in STEP 2 and will only be booked if clinically indicated and with patient consent.

**STEP 3** ☐ Sleep Physician Consultation (Proceed to and complete step 8)

**STEP 4 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 5 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 _____

**STEP 6** OSA50 Score must be ≥5 **AND** Epworth Sleepiness score must be ≥8 to meet criteria for a Medicare funded diagnostic sleep investigation. If the criteria are not met, refer to Step 3 and request a sleep physician consult. **OSA50 Score** ☐ **ESS Score** ☐

**STEP 7 Does the patient have any of the following** **(please tick all that apply)**

☐ 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 for home study (note reason)

Reason: _____

**STEP 8** Referring Doctor's Details: Name: _____

Address: _____ Provider no: _____

Signature: _____ Date: _____