

Please fill the below questionnaires to assess the eligibility of your patient to obtain a fast tracked bulk billed home sleep study.

## EPWORTH SLEEPINESS SCLAE

How likely are you to doze off or fall a sleep in the following situations? *Please circle the appropriate number*

**0 No Chance**

**1 Slight Chance**

**2 Moderate Chance**

**3 High Chance**

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 occur	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after 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
<b>TOTAL SCORE</b>	<b>/ 24 pts</b>			

## 'STOPE BANG' QUESTIONNAIRE

For a Medically subsidised sleep study a patient must score 4 or more *Please circle the appropriate box*

	YES	NO
Do you snore loudly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone observed you stop breathing or choking/gasping during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or are you being treated for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Is your body mass index more than 35kg/m <sup>2</sup> ?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aged older than 50?	<input type="checkbox"/>	<input type="checkbox"/>
Is your gender male?	<input type="checkbox"/>	<input type="checkbox"/>
For men, is your neck size 17 inches/ 43 cm or larger (measured around Adams apple)? For Women, is your neck size 16 inches/ 41 cm or larger?	<input type="checkbox"/>	<input type="checkbox"/>
<b>TOTAL SCORE</b>	<b>/ 8 pts</b>	

## OSA 50 SCREENING QUESTIONNAIRE

*Please add up to the final score*

		<b>IF Yes Score Below</b>
<b>Obesity</b>	Waist circumferences – Male > 102 cm   Female > 88cm	3
<b>Snoring</b>	Has you're snoring ever bothered other people?	3
<b>Apnoeas</b>	Has anyone noticed that you stop breathing during your sleep?	2
<b>50</b>	Are you aged 50 years and over?	2
<b>TOTAL SCORE</b>	<b>/ 10 pts</b>	

*Thank you for your referral to the Sydney Respiratory Specialist Clinic.*

## PATIENT DETAILS

NAME:

DOB:

MEDICARE NUMBER:

PHONE:

ADDRESS

## REFERRING DOCTOR

NAME OF DR:

PROVIDER NO:

## SLEEP STUDY REQUEST

*Please tick appropriate box*

- |   |  |
|---|--|
| <input type="checkbox"/> Fast-tracked bulk billed sleep study according to Medicare guidelines (Please tick the sleep study questionnaires to check Medicare eligibility) | <input type="checkbox"/> Review with a Sleep Specialists (Charges apply) to assess the suitability for a bulked-bill sleep study |
|---|--|

## FOLLOW UP ARRANGEMENTS

*Post sleep study: Please tick the appropriate box*

- |   |  |
|---|--|
| <input type="checkbox"/> Once the sleep study is performed, if sleep Apnoea is diagnosed, would you like us to organize a consultation with one of our sleep specialists to discuss the results and treatment plans with your patient, and use this form as a referral? | <input type="checkbox"/> Would you (referring doctor) like to follow the patient yourself? |
|---|--|

Patients who have an Epworth sleepiness score of 8 together with either a STOP-Bang score of 3 or more/OA50 score of 5 or more are considered high risk of sleep apnoea and **will qualify for a fast-tracked-bulk-billed sleep study** without requiring seeing a sleep physician.

*Please fill the Questionnaires below:*