HOME SLEEP STUDY REFERRAL

Austin Health
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Patient Details

Name	Address	
DOB	Suburb/Town	Postcode
Sex ☐ Male ☐ Female ☐ _____	Phone	
	Mobile	

Indication for Referral

Referrer Details

Name
Practice Address
Provider #
Phone

Please complete these questionnaires so that your patient can get a sleep study quickly

Epworth Sleepiness Scale (ESS)

Date Completed: __ / __ / ___

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? *This refers to your usual way of life in recent times (3 weeks to months). Even if you have not done some of these things recently, try to work out how they would have affected you.*	*Please circle ONE number per row*			
	Never (0)	**Slight (1)**	**Moderate (2)**	**High (3)**
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g. meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon, when circumstances permit	0	1	2	3
Sitting talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

OSA50 Questionnaire

		If yes, SCORE
Obesity	Is your waist circumference* >102cm (men) or >88cm (women)? **Waist measurement at the level of the umbilicus*	(3)
Snoring	Has your snoring ever bothered other people?	(3)
Apnoea	Has anyone noticed that you stop breathing during sleep?	(2)
50	Are you aged 50 years or over?	(2)

Referrer Signature:

Date: ___ / ___ / ____ Duration of referral: ☐ Indefinite ☐ 12 months (default) ☐ Other: _____