RESPECT HEALTH Wellness Clinic

Phone (02) 9053 2268
www.RespectHealthClinic.com.au
15 Euston Street, Rydalmere, NSW 2150

Referral Request

*Please email to **clinic@respecthealthclinic.com.au***

Patient Details

Name _____ DOB_____

Mobile / Phone _____ Email _____

Clinical History (please tick relevant boxes)

Clinical Info

- ☐ Snoring
- ☐ Daytime Lethargy/Sleepiness
- ☐ Nocturnal Gasping/Choking
- ☐ Witness apneas
- ☐ Unrefreshed Sleep
- ☐ Daytime Lethargy/Sleepiness
- ☐ Other:

Comorbidities

- ☐ Restless Legs
- ☐ Sexual Disinterest
- ☐ Bruxism/TMJ Pain
- ☐ Anxiety/Depression/PTSD
- ☐ Concentration Issues

- ☐ Cardiac History
- ☐ CVA / Stroke
- ☐ Hypertension
- ☐ Nocturia
- ☐ Diabetes
- ☐ Respiratory Disease

Services Requested (please tick relevant boxes)

Investigation

- ☐ Level 2 Medicare Home Sleep Study*
- ☐ Level 3 Sleep Study

Consultation

- ☐ Sleep Therapist Consult
- ☐ Naturopath / Nutrition Consult

Therapy

- ☐ CPAP Initiation / Review
- ☐ Insomnia Therapy

*Medicare Criteria for Level 2 Home Sleep Test

To **qualify for Medicare Rebate** home sleep study test, the patient needs to:

- **not** had a home sleep test in the **past 12 months** and **aged 18 years and over**.
- **EPWORTH ≥ 8 *and* either OSA50 score ≥ 5 *or* STOPBANG ≥ 3**.

If the patient does not qualify, please refer for Sleep Physician review

Epworth Sleepiness Questionnaire

How likely patient to dose or fall asleep in the following situations.

Circle the response that best describes:	**Never**	**Slight**	**Moderate**	**High**
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. theatre or 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 and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car as a driver stopped for a few minutes in traffic	0	1	2	3
	ESS Total _____ (Min 8 required)			

STOP-BANG / OSA 50

	STOP-BANG	**OSA50**
Feel tired, fatigued, or sleepy during the daytime?	1	-
Do you have (or are you being treated for) high blood pressure?	1	-
BMI > 35 kg/m2	1	-
Neck circumference > 40 cm	1	-
Gender Male?	1	-
Has your snoring ever bothered other people?	1	3
Anyone observed you stop breathing or choking/gasping during sleep?	1	2
Aged 50 years or over?	1	2
Waist circumference (male > 102cm, female > 88cm)	-	3
TOTAL		
Minimum of either required	3	5

Referring Doctor Details

Doctor Name _____ Provider # _____

Phone _____ Email _____

Doctor Signature _____ Date of Referral _____