

PATIENT DETAILS

Name	<input type="text"/>	Address	<input type="text"/>
Date of birth	<input type="text"/>		<input type="text"/>
Phone	<input type="text"/>		<input type="text"/>

SLEEP SERVICES

<input type="checkbox"/> Specialist Consultation	<input type="checkbox"/> Home Sleep Test	<input type="checkbox"/> ASV Sleep Test	<input type="checkbox"/> Bi-Level Sleep Test	<input type="checkbox"/> Light Therapy
<input type="checkbox"/> CPAP Therapy	<input type="checkbox"/> Review Sleep Test	<input type="checkbox"/> MSLT Sleep Test	<input type="checkbox"/> TCCO2 Sleep Test	
<input type="checkbox"/> CPAP Titration Test	<input type="checkbox"/> Diagnostic Sleep Test	<input type="checkbox"/> MWT Sleep Test	<input type="checkbox"/> Oxygen Titration Test	

~Please complete the Stop Bang Questionnaire and Epworth Sleepiness Scale on the back of this page.~

SYMPTOMS & SLEEP HISTORY

<input type="checkbox"/> Snoring	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Restless Legs/Abnormal Limb Movements
<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Witnessed Apneas	

RESPIRATORY SERVICES

<input type="checkbox"/> Specialist Consultation	<input type="checkbox"/> Bronchial Provocation (Mannitol)	<input type="checkbox"/> Spirometry
<input type="checkbox"/> 6 Minute Walk Test	<input type="checkbox"/> Gas Transfer (DLCO/TLCO/CO Diffusion)	<input type="checkbox"/> Bronchodilator Response (Salbutamol)
<input type="checkbox"/> Lung Volumes (Plethysmography)	<input type="checkbox"/> Maximal Inspiratory & Expiratory Pressures	

PERIOPERATIVE AND OTHER MEDICAL SERVICES

<input type="checkbox"/> General Medicine Consultation	<input type="checkbox"/> Perioperative Optimisation	<input type="checkbox"/> Diabetes Management	<input type="checkbox"/> Heart Failure Management
<input type="checkbox"/> Oncology Consultation	<input type="checkbox"/> Metabolic Syndrome Management		

COMORBIDITIES & OTHER MEDICAL HISTORY

<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obesity	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Cigarette Smoker	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Further Notes Attached	

CLINICAL NOTES

REFERRER DETAILS

Signature	<input type="text"/>	Address	<input type="text"/>
Name	<input type="text"/>		<input type="text"/>
Provider No.	<input type="text"/>		<input type="text"/>
Date	<input type="text"/>	Phone	<input type="text"/>

AVAILABLE SERVICES BY LOCATION

	BALLARAT 1101 Howitt Street Wendouree, VIC 3355	GEEELONG Epworth Hospital Suite 6.10, 1 Epworth Place Waurin Ponds, VIC 3216	HAMILTON 3 Kitchener Street Hamilton, VIC 3300	HOBART 8 Knopwood Street Battery Point, TAS 7004	SUNSHINE Sunshine Private Hospital Suite 5.2, 145 Furlong Road St Albans, VIC 3021	WARRNAMBOOL 2 Fitzroy Road Warrnambool, VIC 3280
SLEEP	Specialist Consultation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Home Sleep Test	<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>
	Diagnostic Sleep Test	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
	Review Sleep Test	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
	CPAP Therapy	<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>
	CPAP Titration Test	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
	Bi-Level Sleep Test	<input checked="" type="checkbox"/>				
	Light Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Adaptive Servo Ventilation (ASV) Sleep Test	<input checked="" type="checkbox"/>				
	Multiple Sleep Latency Test (MSLT)	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
	Maintenance of Wakefulness Test (MWT)	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
	Oxygen Titration Sleep Test	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		
Transcutaneous Carbon Dioxide (TCCO2) Sleep Test	<input checked="" type="checkbox"/>					
RESPIRATORY	Specialist Consultation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Lung Volumes (Plethysmography)	<input checked="" type="checkbox"/>				
	6 Minute Walk Test	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Bronchial Provocation (Mannitol)	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Gas Transfer (DLCO/TLCO/CO Diffusion)	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Maximal Inspiratory & Expiratory Pressures (MIPS/MEPS)	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Spirometry	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Bronchodilator Response (Salbutamol)	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
PERIOPERATIVE / OTHER MEDICAL	General Medicine Consultation	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	
	Oncology Consultation	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	
	Perioperative Optimisation	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	
	Heart Failure Management	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	
	Diabetes Management	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	
	Metabolic Syndrome Management	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	

Please complete these questionnaires if you are being referred for sleep services.

STOP BANG QUESTIONNAIRE (SBQ)

PLEASE TICK ALL THAT APPLIES.
EACH TICK EQUALS ONE SCORE.

Does the patient **SNORE** loudly?

Does the patient often feel **TIRED**, fatigued, or sleep during daytime?

Has anyone **OBSERVED** the patient stop breathing during sleep?

Does the patient have or is the patient being treated for high blood pressure?

Does the patient have a BMI more than 35?

AGE over 50 years old?

NECK circumference (shirt size) more than 40cm / 16 inches?

Is the patient a **MALE**?

TOTAL SCORE

EPWORTH SLEEPINESS SCALE (ESS)

HOW LIKELY IS THE PATIENT TO DOZE OFF?
TICK ONE BOX FROM EACH ROW.

SCORE (TICK ONE)
0 1 2 3

Sitting and reading

Watching television

Sitting inactive in a public place (eg. theatre or meeting)

As a passenger in a car for an hour without a break

Lying down in the afternoon when circumstances permit

Sitting and talking to someone

Sitting quietly after lunch without alcohol

In a car, while stopped for a few minutes in traffic

TOTAL SCORE (add up all boxes ticked)