



PATIENT DETAILS

Title: Full name:

DOB: Gender: Pension Number:

Address:

Phone number: Drivers Licence Type:

Medicare Card No: Ref No: Expiry:

STOP BANG Questionnaire		Yes or No for each question
S)nore	Do you snore?	<input type="text"/>
T)ired	Do you feel fatigued during the day AND / OR do you wake feeling like you haven't slept?	<input type="text"/>
O)bstruction	Have you been told you stop breathing at night AND / OR do you wake choking or gasping for air?	<input type="text"/>
P)ressure	Do you have high blood pressure AND / OR are you on blood pressure medications?	<input type="text"/>
If yes to 2 or more questions above at risk of OSA		
B)MI Body Mass Index	Height cm <input type="text"/> Weight kg <input type="text"/>	Is your BMI > 35 kg/m ² ? <input type="text"/>
A)ge	Are you 50 or more years old?	<input type="text"/>
N)eck	Do you have a neck circumference >40cm?	<input type="text"/>
G)ender	Are you male?	<input type="text"/>
TOTAL questions answered YES =		<input type="text"/>

The more questions answered yes in the BANG portion, the higher the risk of having moderate to severe OSA.

EPWORTH sleepiness scale (Score 0-3 for each situation)

What are the chances of you dozing off or falling asleep in the below scenarios? Feeling tired is not counted. The situations refer to your life recently. *If you have not been doing some of these activities, decide how they would have affected you.* Choose the most appropriate number from the following scale for each scenario.

0 = No chance of dozing 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = high chance of dozing

Sitting Reading	<input type="text"/>	Lying down in the afternoon when circumstances allow	<input type="text"/>
Watching TV	<input type="text"/>	Sitting and talking to someone	<input type="text"/>
Sitting inactive in a public place (e.g. meeting or theatre)	<input type="text"/>	Sitting quietly after lunch without alcohol	<input type="text"/>
Sitting in a car as a passenger for an hour without a break	<input type="text"/>	Sitting in a car stopped in traffic for a few minutes	<input type="text"/>

Total score for the above situations: 0-10 Normal range, 11-14 Mild sleepiness, 15-17 Moderate sleepiness, >18 Severe sleepiness

Total Score

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Please complete the above questionnaires with your patient. If they answer Yes to **3** or more questions in the STOP BANG AND score 8 or more with the ESS they are eligible for an ambulatory in home sleep study to be billed through Medicare WITHOUT seeing a sleep or respiratory physician first and this will be organised promptly.

If they do not answer Yes to **3** or more STOP BANG questions AND score 8 or more on the ESS, a sleep or respiratory physician needs to review the patient prior to any home sleep study due to Medicare requirements.

SERVICE REQUESTED

Diagnostic Home Sleep Study - to confirm diagnosis of Obstructive Sleep Apnoea and/or specialist consultation where deemed appropriate.

Patient Presentation

Excessive daytime sleepiness?	<input type="checkbox"/>	Insomnia?	<input type="checkbox"/>
Nocturia?	<input type="checkbox"/>	Congestive Heart Failure?	<input type="checkbox"/>
Depression?	<input type="checkbox"/>	*Narcolepsy?	<input type="checkbox"/>
Hypertension?	<input type="checkbox"/>	*Abnormal Movements in sleep?	<input type="checkbox"/>
Type 2 Diabetes?	<input type="checkbox"/>		

*Narcolepsy and parasomnias cannot be accurately diagnosed on an ambulatory study and will be redirected to a sleep physician

CLINICAL HISTORY (INCLUDING DETAILS OF ANY MOTOR VEHICLE ACCIDENTS AND OF ANY EPISODES OF FALLING ASLEEP WHILST DRIVING)

CURRENT MEDICATIONS

REFERRING DOCTOR

Full Name:

Address:

Provider Number: Signed: Referral Date:

Email: info@healthdynamics.com.au Fax: 03 4206 7880 HealthLink ID: hlthdtas

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