

Referral

For all appointments and results:

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WEST PERTH • PERTH CBD • PORT HEDLAND • COCKBURN • KALGOORLIE • MANDURAH • BUNBURY



Patient Details:

Name: _____ D.O.B: _____

Address: _____

Postcode: _____

Telephone: (H) _____ (W) _____ (M) _____

Medicare #: _____ IRN: _____ Expiry: _____

Sleep Services:

- | | |
|--|--|
| <input type="checkbox"/> Sleep Study
(specialist consultation and/or treatment if indicated) | <input type="checkbox"/> Provent Trial
(with validating sleep study) |
| <input type="checkbox"/> Specialist Consultation
- Dr Andrew Webster | <input type="checkbox"/> Night Shift Trial |
| <input type="checkbox"/> CPAP Trial | <input type="checkbox"/> Insomnia Management
(includes specialist consult) |
| <input type="checkbox"/> CPAP Support | <input type="checkbox"/> Chronic Disease Management |

Clinical Details:

- | | | |
|---|--|---|
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Daytime Somnolence | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Commercial Driver/Operator |
| <input type="checkbox"/> Witnessed Apnoea | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> 45 years + | <input type="checkbox"/> Cardiac Failure | |

Height: _____ Weight: _____ BMI: _____ Neck Circumference: _____

Referring Doctor:

Name: _____ Provider #: _____

Practice: _____

Signature: _____ Date: / /

PLEASE COMPLETE QUESTIONNAIRE ON THE BACK OF THIS FORM

PLEASE BRING YOUR CURRENT REFERRAL TO YOUR APPOINTMENT

Dr Andrew Webster MBChB, FRACP (Respiratory and Sleep Physician)

PLEASE BRING THIS COMPLETED QUESTIONNAIRE AND REFERRAL TO YOUR APPOINTMENT, OR SUBMIT VIA EMAIL BELOW. Thank You

EPWORTH SLEEPINESS SCALE

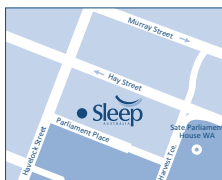
How likely are you to doze off?	Never (0)	Slight (1)	Mod (2)	High (3)
Sitting and Reading				
Watching TV				
Sitting inactive in a public place				
Being inactive in a car as a passenger				
Lying down to rest in the afternoon				
Sitting and chatting to someone				
Sitting quietly after lunch				
In a car while stopped in traffic				

SCORE = OUT OF 24

STOP-BANG QUESTIONNAIRE

Please answer YES or NO to below questions.	YES	NO
Do you snore loudly?		
Do you often feel tired, fatigued, or sleepy during the daytime?		
Has anyone observed you stop breathing during your sleep?		
Do you have or are you being treated for high blood pressure?		
Are you obese/ very overweight - BMI more than 35 kg/m ² ?		
Age over 50 years old?		
Neck Circumference (collar size > 43cm male, 41cm female)		
Are you male?		

SCORE = OUT OF 8



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