Phone: 02 9812 3709 *Fax: 02 9812 3844* *Email: reception@mqrs.com.au*

Clinical Director of Sleep Investigation Unit: Dr Lydia Makarie Rofail
Sleep Physicians: A/Prof Claude Farah, Dr Tajalli Saghaie, A/Prof Jonathan Williamson

SLEEP DISORDERS UNIT REQUEST FORM

First Name: **Surname:**

DOB: **Gender: Male / Female** **Medicare No:** **Ref No:**

Address:

Home(Ph): **Work((Ph):** **Mobile**

Email:

Available to come at short notice: Yes / No **Availability details:**

Health Fund Name: **Membership No:** **DVA Number:**

SLEEP STUDY Requested: ***Please tick required test (1-5)***

□ **1. Portable/Home Diagnostic Sleep study - Item 12250** (Must satisfy Medicare Criteria a) or b))
a) Sleep/Respiratory Physician Request after face to face consultation **OR**
b) Questionnaire-(See Appendix 1) ESS (=or>8) **PLUS** OSA50 score of 5 **OR** STOP – BANG (=> 4)

□ **2. Adult Laboratory Diagnostic Sleep Study - Item 12203**
Referring physician must complete and sign mandatory Medicare requirement for in laboratory diagnostic sleep study(Appendix 2) **AND** satisfy a) or b)
a) Sleep/Respiratory Physician Request after face to face consultation **OR**
b) Questionnaire--(See Appendix 1) ESS (=or>8) **PLUS** OSA50 score of 5 **OR** STOP – BANG (=> 4)

□ **3. Adult Pressure Titration Study - Item 12204-** *Can **ONLY** be requested by a Sleep/Respiratory Physician*

□ **4. Adult Treatment Review Sleep Study Item 12205-** *Can **ONLY** be requested by a Sleep/Respiratory Physician*
(CPAP or MAS or oxygen or post upper airway surgery or >10% weight loss in previous 6 months)

□ **5. Adult Diagnostic Further Investigation Sleep Study- Item 12208-** (where initial diagnostic study **FAILED** because of insufficient sleep, defined as sleep efficiency of 25% or less) and (Must satisfy Medicare Criteria a) or b))
a) Sleep/Respiratory Physician Request after face to face consultation **OR**
b) Questionnaire-(See Appendix 1) ESS (=or>8) **PLUS** OSA50 score of 5 **OR** STOP – BANG (=> 4)

ADDITIONAL TESTS: □ TcCO2 □ PM ABG □ AM ABG

PRIORITY: □ **Urgent** (4 weeks) □ Semi Urgent (12 weeks) □ Elective

Please indicate if sleep study performed and billed within 12 months? Yes/ No **If Yes, please circle one**
Item 12203 Item 12204 Item 12205 Item 12208

CLINICAL HISTORY:

Follow up (Please tick one): ☐**Sleep Physician at Macquarie** ☐**Referring Doctor to review**

Referring Physician Name: Physician Signature:
Address: Phone:
Email Fax
Provider Number: Date:

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Study Date: **Follow up Appt:** **Pt consent completed: Yes / No** **Pt info sheet: Yes / No** **Confirmed: Yes / No**

MUH Booking form completed: Yes / No **Date faxed/emailed to MUH bookings:** **Admin Staff initials:**

Appendix 2 Referring Physician To Complete

Mandatory Medicare requirement for LABORATORY diagnostic sleep study(Item 12203)

Please tick at least **ONE** item from 1) **or** 2) and sign below:

I have determined that an in-laboratory overnight diagnostic sleep study is necessary to investigate for:

1) Suspected obstructive sleep apnoea syndrome where the patient is assessed as not suitable for an unattended sleep study because of:

☐ (a) intellectual disability or cognitive impairment;

☐ (b) physical disability with inadequate carer attendance;

☐ (c) significant co-morbid conditions including neuromuscular disease, heart failure or advanced respiratory disease where more complex disorders are likely;

☐ (d) suspected respiratory failure where attended measurements are required, including measurement of carbon dioxide partial pressures;

☐ (e) suspected parasomnia or seizure disorder;

☐ (f) suspected condition where recording of body position is considered to be essential and would not be recorded as part of an unattended sleep study;

☐ (g) previously failed or inconclusive unattended sleep study;

☐ (h) unsuitable home environment including unsafe environments or where patients are homeless;

☐ (i) consumer preference based on a high level of anxiety about location of study or where there is unreasonable cost or disruption based on distance to be travelled, or home circumstances.

Or

2) I deem this patient has:

☐ (a) Suspected central sleep apnoea syndrome;

☐ (b) Suspected sleep hypoventilation syndrome;

☐ (c) Suspected sleep related breathing disorder in association with non respiratory co- morbid conditions including heart failure, significant cardiac arrhythmias, neurological disease, acromegaly, hypothyroidism, advanced respiratory disease/respiratory failure;

☐ (d) Unexplained hypersomnolence not attributed to inadequate sleep hygiene or environmental factors;

☐ (e) Suspected parasomnia or seizure disorder where clinical diagnosis cannot be established on clinical features alone (including associated atypical features, vigilance behaviours; or failure to respond to conventional therapy);

☐ (f) Suspected sleep related movement disorder, where the diagnosis of restless legs syndrome is not evident on clinical assessment.

☐ Other reasoning:_____

Referring Physician Name:_____
Signature: _____ **Date:** _____

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Respiratory and Sleep Physician Approval

Name:

Signature: Date:

Appendix: 1
Questionnaires to fulfil Medicare criteria for a diagnostic sleep study

Name: _____ DOB: _____ Date completed: _____

Height: _____m Weight: _____kg Neck circumference: _____cm

Waist circumference: _____cm BMI: _____Kg/m^2

Mandatory Epworth Sleepiness Scale

0 - No chance of dozing 1 - Slight chance of dozing
2 - Moderate chance of dozing 3 - High chance of dozing

(Please circle appropriate number for each of the following)

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 a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3

Criteria Total Score equal or >8 □

AND satisfy **ONE** of the following (a or b) Questionnaires:

a) OSA 50 Screening Questionnaire (If yes, circle)

Waist circumference (at umbilicus): Male > 102cm / Female > 88cm	3
Has your snoring ever bothered other people?	3
Has anyone noticed you stop breathing during your sleep?	2
Are you aged 50 years or over?	2

Criteria Total Score >5 (High Risk for OSA) □

OR

b) STOP-BANG (circle answer)

Do you *SNORE* loudly? (Louder than talking or heard through closed doors)	Yes	No
Do you often feel *TIRED*, fatigued, or sleepy during daytime?	Yes	No
Has anyone *OBSERVED* you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood *PRESSURE*? Yes	No	
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference >17 inches (43 cm) for males, 16 inches (41cm) for female	Yes	No
GENDER: Male?	Yes	No

Criteria Answered Yes to total equal or >4 questions (High Risk for OSA) □

Patient Signature: _____

*Sleep Physician review is recommended if questionnaire data does not meet Medicare criteria