Sleep Management Services

Referral Form

Dr. Kevin Chan FRACP & Associates

Patient's name: _____ D.O.B: _____ Gender: _____

Address: _____ Phone: _____

Email: _____ Occupation: _____

Services requested: (Please choose one or more)

☐ 1. Sleep / Respiratory Physician consultation – Consultation rates vary.
(Medicare and DVA rates may apply. Private insurance rates may apply)

☐ 2. Unattended (ambulatory) diagnostic sleep assessment and management advice

☐ 3. Attended (In-lab) diagnostic sleep assessment (available in selective areas) and management advice

☐ 4. Comprehensive Lung Function – (Spirometry, Lung Volumes, DLCO) (available in selective areas)

☐ 5. Spirometry (pre & post-Bronchodilator)

Please kindly assist us by providing the following information if service 2 is chosen:

In accordance with the MBS, a Consultant Sleep Physician will assess the following information to determine whether the sleep study is eligible for a Medicare-rebate.

A. Does your patient have any of the following? (STOP Bang Questionnaire) Please tick when applicable

☐ Snoring loudly (enough to be heard through closed doors / affecting bed-partner's sleep)
☐ Tired, fatigued or sleepy during the wakeful hours
☐ Observed apnoeas or choking
☐ Being on treatment for hypertension (please specify_____)
☐ BMI > 35 (please specify _____)
☐ Age > 50 (please specify_____)
☐ Neck size (>= 43 cm for male and 41 cm for female: please specify _____)
☐ Male Gender.

B. How likely is your patient to doze off or fall asleep in the following situations, in contrast to feeling just tired?
(Epworth Sleepiness Score) Please score each

0 = would never doze / 1 = slight chance of dozing / 2 = moderate chance of dozing / 3 = high chance of dozing

__ Sitting and reading
__ Watching TV
__ Sitting, inactive in a public place (e.g. a theatre or a meeting)
__ As a passenger in a car for an hour without a break
__ Lying down to rest in the afternoon when circumstances permit
__ Sitting and talking to someone
__ Sitting quietly after a lunch without alcohol
__ In a car, while stopped for a few minutes in the traffic

C. Does your patient have any of the following conditions? If "YES", please tick

__ Intellectual disability or cognitive impairment
__ Physical disability & inadequate career attendance
__ Suspected/confirmed parasomnia or seizure disorder
__ Previously failed or inconclusive unattended sleep study
__ Suspected respiratory failure
__ Neuromuscular disease
__ Arrhythmia
__ Advanced respiratory disease
__ Domiciliary oxygen therapy
__ Suspected obesity hypoventilation
__ Other unstable cardiac diseases
__ Significant mental health issues
__ Logistical / discretionary or psychosocial factors against an attended / unattended sleep study (please specify which type of study)

Significant rhinosinus condition? ☐ Yes ☐ No

Are there any other co-morbidities / important medical information?

_____

_____

For this referral to be valid, please ensure the following details are completed:

Referring Dr. name _____ Provider No. _____

Practice name _____ Phone _____ Fax _____

Address _____

Email _____ ☐ Medical objects secure messaging

Referring Dr. signature: _____ Referral Date: _____

Please email the completed form to : referral@sleepmgt.com
or FAX: NSW: 02 8088 1165 ACT: 02 6169 3193
Our staff will contact the patient to book a convenient appointment.
For any enquiries, please contact 1300 801 835