

# HOME SLEEP STUDY REQUEST



Monash Health  
246 Clayton Road, Clayton Vic 3168

Tel 9594 2280 or 9594 2836  
Fax 9594 6080  
Email [sleepbooking@monashhealth.org](mailto:sleepbooking@monashhealth.org)

<b>Patient Details</b> <i>ALL fields must be completed.</i>				
Name		Address		
DOB		Suburb	Postcode	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Phone		
Email		Mobile		
Medicare #		Monash UR #		
Please complete the two questionnaires below to ensure the patient has a high probability for symptomatic moderate to severe obstructive sleep apnoea.				
<b>Epworth Sleepiness Scale</b> <i>Please circle only one number per row - 0 = Never / 1 = Slight / 2 = Moderate / 3 = High</i>				
<i>How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times (3 weeks to months). Even if you have not done some of these things recently, try to work out how they would have affected you.</i>				
Sitting and reading .....	0	1	2	3
Watching TV .....	0	1	2	3
Sitting inactive in a public place .....	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 talking to someone .....	0	1	2	3
Sitting quietly after lunch without alcohol .....	0	1	2	3
In a car, while stopped for a few minutes in traffic .....	0	1	2	3
<b>Scoring:</b> add the value of all circled numbers - Total must be <b>8 or higher</b> to be eligible for direct referral for a home sleep study. Values below this will be referred for a Sleep Specialist Consultation first.			<b>TOTAL</b>	
<b>OSA50</b> <i>Please circle only one number per row</i>				
Obesity	Is your waist circumference >102cms (male) or >88cms (female)? .....			3
Snoring	Has your snoring ever bothered other people? .....			3
Apnoea	Has anyone noticed that you stopped breathing during sleep? .....			2
50	Are you aged 50 years or over? .....			2
<b>Scoring:</b> add the value of all circled numbers - Total must be <b>5 or higher</b> to be eligible for direct referral for a home sleep study. Values below this will be referred for a Sleep Specialist Consultation first.			<b>TOTAL</b>	
<b>Indication for Study</b> <i>Ensure sufficient relevant Clinical History/ Study Indications / Specific Instructions</i>				
Site <input type="checkbox"/> Clayton		Priority <input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> Cancellation List		
<b>Care Requirements</b> <i>ALL questions MUST be answered. Patient must bring a carer if required.</i>				
Does your patient require assistance with any day to day activities?		<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please specify: _____		
Does your patient require assistance walking a distance of 500 metres?		<input type="checkbox"/> Yes <input type="checkbox"/> No _____		
<b>Sleep Specialist Review</b> <i>ONE option MUST be selected.</i>				
<input type="checkbox"/>	Option 1	Monash Sleep Specialist consultation PRIOR to sleep study		
<input type="checkbox"/>	Option 2	Monash Sleep Specialist consultation AFTER sleep study (Default Option)		
<input type="checkbox"/>	Option 3	Direct Sleep Study, follow up by referring specialist (patient to schedule with specialist)		
<b>Referrer Details</b> <i>ALL fields MUST be completed</i>			<b>OFFICE USE ONLY</b>	
Name			Study	
Practice			Site	
Provider #			Day	
Phone		Date	Date	
Signature _____			Time	
			Admin	

Scientist Approval	Name: _____	Physician Approval	Name: _____
	Date: ____ / ____ / ____		Date: ____ / ____ / ____