SLEEP SERVICES REFERRAL FORM

Please complete this referral form if your patient wishes to be considered for a free diagnostic home sleep study or, if already diagnosed with obstructive sleep apnoea, a CPAP trial. Completed forms should be returned to the patient's local Friendlies pharmacy. For more information on this service or our other health services, or to find a pharmacy location visit **friendliespharmacies.com.au.**

PATIENT DETAILS

Name

Occupation

Date of Birth

Address

Postcode

Phone / Mobile

Medicare Number

Medicare Valid To

Gender

☐ Male ☐ Female

HBF Member

☐ Yes ☐ No

HBF Member Number

DOCTOR DETAILS

Name

Provider Number

Address

Postcode

Email

Phone

Doctor's Signature

Date (referral valid for 12 months)

REFERRAL DETAILS Doctor to complete

Referring to Friendlies for

☐ Home Sleep Study ☐ CPAP Trial

Relevant Conditions

☐ Atrial Fibrillation ☐ Cardiac Failure ☐ Depression ☐ Overweight / Obesity ☐ Stroke/TIA

☐ Hypertension ☐ Restless Legs ☐ COPD ☐ Type 2 Diabetes ☐ Other

Measurements

Height

Weight

Neck Circumference

Relevant Clinical History and Medications (additional information can be attached)

Important information overleaf. Please complete both pages.

ESSENTIAL SCREENING CRITERIA

STOP-Bang Questionnaire Model (please tick)

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	☐ Yes	☐ No
Do you often feel fatigued, or sleepy during the 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 35 kg/m^2?	☐ Yes	☐ No
Age over 50 years old?	☐ Yes	☐ No
Neck circumference greater than 40cm?	☐ Yes	☐ No
Are you male?	☐ Yes	☐ No

Note: Answering Yes to more than 4 questions is required for a bulk-billed study. If your patient does not meet this criteria a consultation with a Sleep Physician is required prior to a sleep study being undertaken.

What level of risk for OSA do you consider this patient? ☐ High ☐ Low

Epworth Sleepiness Scale

Doctor to ask questions to patient:

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. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the appropriate number for each situation. It is important that you answer each question as best you can.

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. cinema, meeting)	☐
As a passenger in a car for an hour without a break	☐
Lying down resting in the afternoon when circumstances permit	☐
Sitting and chatting to someone	☐
Sitting quietly after lunch (not having had alcohol)	☐
In a car when you stop in traffic for a few minutes	☐
Your overall total	☐

Scores below 8 do not qualify for a bulk-billed study and a consultation with a Sleep Physician is required.

FIND A PHARMACY

To find your closest Friendlies visit **www.friendliespharmacies.com.au/pharmacies**