|  |  |
| --- | --- |
| Click or tap to enter a date. | **Tel: 1300 743 782 (SIESTA)****Mob: 0431 390 548****Fax: (07) 3112 4107****reception@siestasleepservice.com****Head Office:**10A, 3352 Pacific HwySpringwood QLD 4127 |
| Dr Geoffrey Williams *FRACP Respiratory and Sleep Physician* Provider No. 408456W **REFERRAL LETTER**Dear Dr Geoffrey Williams,

|  |
| --- |
| **RE: Patient Full Name (Inc. salutation)** |
| **DOB:** *Insert Here* |
| **Phone**: *Insert Here* |
| **Address:** *Insert Here* **Height (cm):** *Insert Here***Weight (Kg):** *Insert Here* |
| **CLINICAL DETAILS*****\*\*\*Please note: A score of 5 or more******is required to meet Bulk Billing Criteria*** |
| [ ]  **Witnessed Apnea** *(2 points)*[ ]  **Snoring** *(3 points)*  |
| [ ]  **Obesity** *(3 points)* Waist measurement (cm): *Waist* *-Waist Circumference Male >102cm* *-Waist Circumference Female>88cm* |
| [ ]  **Aged 50 years or more** *(2 points)* |
| [ ]  **Hypertension** |
| [ ]  **Diabetes****Additional Clinical Notes:***Insert Here* |

 | **TEST/SERVICE REQUIRED****In-Home Location**[ ]  Sunshine Coast[ ]  Brisbane[ ]  Gold Coast**In-Home Test** [ ]  Sleep Study [ ]  CPAP Trial **In-Clinic Test** [ ]  Fully-Attended Level 1 Sleep Study[ ]  CPAP Titration Study[ ]  CPAP Reassessment**In-Clinic Location**[ ]  Sunshine Coast[ ]  Brisbane**REPORT REQUIREMENTS**[ ]  Urgent[ ]  Standard**COMMUNICATION METHOD**[ ]  Fax[ ]  Medical Objects[ ]  Other: *Preferred Method*

|  |
| --- |
| **REFERRING DOCTOR’S DETAILS** |
| **Full Name (Inc. salutation)**Provider NumberPractice AddressPhone NumberFax Number |

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**BULK BILLING requirement:** Please complete attached **OSA 50 Screening Questionaire** and **Epworth Sleepiness Scale**



 ***Your trusted sleep health provider***

**THE EPWORTH SLEEPINESS SCALE**

*To be eligible for a Bulk Billed Sleep Study please complete this scale (Score 8 or above).*

DATE: Click or tap to enter a date.

PATIENT FULL NAME: *Insert Here*

DOB: *Insert Here*

**0= No chance of dozing**

**1= Slight chance of dozing**

**2= Moderate chance of dozing**

**3= High chance of dozing**

How likely are you to doze or fall asleep in the following situations, in contrast to feeling just tired?

If you have not done some of these things recently, try to work out how they would have affected you.

|  |  |
| --- | --- |
| **SITUATION** | **CHANCE OF DOZING** |
| Sitting and reading | Choose an item. |
| Watching TV | Choose an item. |
| Sitting inactive in a public place | Choose an item. |
| As a passenger in a car for an hour without a break | Choose an item. |
| Lying down to rest in the afternoon  | Choose an item. |
| Sitting and talking to someone | Choose an item. |
| Sitting quietly after lunch without alcohol | Choose an item. |
| In the car, stopped at traffic lights for a few minutes  | Choose an item. |

**TOTAL out of 24**

*Insert Total*