REQUEST FOR HOME SLEEP STUDY MEDICARE ITEM 12250

REFERRAL FORM | FAX TO 07 3381 9025

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Email: info@SleepStudyBrisbane.com.au

Date of this referral ______________ **Weight** _________ **Height** ________

Patient name ___________________________________ **DOB** __________

Phone _______________________ **Commercial Driver's license: Yes No**

Address ____

Please tick the following services required:

○ **Home sleep study** Item 12250

○ **For DVA Gold Card Holders** DVA Gold Number ____________________TRN Number ________________________________

OTHER THERAPY REQUIRED

○ **CPAP/APAP treatment trial** for the treatment of sleep apnea
○ **CPAP therapy review with oximetry** *(pressure, compliance, mask review & full equipment check)*
○ **Supply of DVA approved equipment and service** ** For eligible DVA patients*

ESS AND OSA 50 Screening: Both requirements must be met to be eligible for Medicare Item 12250

ESS Epworth Sleepiness Scale

For a Medicare-subsidised Home Sleep Study, *a patient must score 8 or more on the following*

How likely are you to doze off in the following situations?				
Sitting and reading	○ 0	○ 1	○ 2	○ 3
Watching television	○ 0	○ 1	○ 2	○ 3
Sitting inactive, in a public space	○ 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
As a passenger in a car for an hour without a break	○ 0	○ 1	○ 2	○ 3
In a car while stopped for a few minutes in traffic	○ 0	○ 1	○ 2	○ 3
SCORES	_____	_____	_____	_____

Use the following scale to choose the most appropriate answer:
0 – No chance
1 – Slight chance
2 – Moderate chance
3 – High chance

TOTAL SCORE ____________

OSA Obstructive Sleep Apnea - 50 Screening

For a Medicare-subsidised Home Sleep Study, the OSA 50 Screening must be ≥ 5

		Please circle
Obesity	Waist circumference* - Male > 102 cm or Female > 88 cm	3
Snoring	Has your snoring ever bothered other people?	3
Apnoeas	Has anyone noticed that you stop breathing during your sleep?	2
50 Age	Are you aged 50 years or over?	2
	TOTAL SCORE	_______ / 10points

SYMPTOMS (Please mark appropriate circle/s)

○ Snoring ○ Witness apneas / nocturnal gasping / choking ○ Daytime lethargy / Sleepiness ○ Cognitive Impairment
○ Waking with headache ○ Weight gain ○ Restless sleep ○ Insomnia ○ Irritability

RELEVANT MEDICAL CONDITIONS (Please mark appropriate circle/s)

○ Hypertension ○ Cardiac failure ○ Store / TIA ○ COPD ○ Overweight ○ Pacemaker ○ Type II Diabetes
○ Atrial fibrillation ○ Family history (OSA) ○ Clinical History (optional, attach notes to this referral) ○ Other_________________

For this referral to be valid, please ensure the following details are completed OR place GP stamp below. Thank you.

Referring Dr. Name
Practice Name
Address
Email

Phone Number_______________________
Provider Number _____________________
Referring Doctor's Signature:

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