Tewantin
Gympie
Maroochydore

Bli Bli
Birtinya

Dusk till Dawn SLEEP CENTRE

Head Office Phone: 07 5455 6622 Fax: 07 5455 6633
Email: admin@dusktilldawnsleep.com.au

Patient Details

Patient's Name: _____

Phone Number: _____

DOB: _____ Medicare Number: _____

Email: _____

Commercial License
☐ Yes ☐ No

DVA
☐ Yes ☐ No

Service Request (Please tick appropriate)

- ☐ **Ambulatory Sleep Study (Level 2 PSG medicare approved)**
- ☐ **Ambulatory Sleep Study (Level 2 PSG medicare NOT approved)**
- ☐ **OSA screening test (Level 3 - private fee applies)**
- ☐ **Paediatric Sleep Study (private fee applies)**
- ☐ **CPAP Review**
- ☐ **CPAP Trial**
- ☐ **Overnight Oximetry**
- ☐ **Treatment Options Consultation**
- ☐ **Holter Monitoring**
- ☐ **Physician Review**
- ☐ **Rhinomanometry/Airway Resistance**

Epworth Sleepiness Scale (Medicare criteria must score 8 or more of the following)

How likely are you to doze off or fall asleep in the following situations?	Never	Slight	Moderate	High
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 and talking to someone.	0	1	2	3
Sitting quietly after lunch without alcohol.	0	1	2	3
In a car stopped for a few minutes in traffic.	0	1	2	3
Total out of 24:				

STOP BANG Questionnaire
(Medicare criteria must score 3 or more of the following)

Do you Snore Loudly?	☐ Yes ☐ No
Do you often feel Tired, Fatigued, or Sleepy during the daytime?	☐ Yes ☐ No
Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep?	☐ Yes ☐ No
Do you have or are you being treated for High Blood Pressure?	☐ Yes ☐ No
Is your Body Mass Index more than 35 kg/m2	☐ Yes ☐ No
Are you over 50 years of age?	☐ Yes ☐ No
Neck size large: For male, is your shirt collar 43cm or larger? For female, is your shirt collar 41cm or larger? (Measured around Adams apple)	☐ Yes ☐ No
Are you Male?	☐ Yes ☐ No
Total score	

Referring Doctor Details

Name: _____

Provider Number: _____

Address/Practice Name: _____

_____ Ph: _____

Signature: _____ Date: _____

Clinical History Notes

- ☐ Restless Legs ☐ COPD ☐ Heart Disease
- ☐ Depression ☐ Diabetes ☐ Neurological
- ☐ Nocturia ☐ Insomnia ☐ CVA
- ☐ Other (Please Explain) _____