



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	PHONE NO.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility: NEPEAN

AMBULATORY SLEEP STUDY REQUEST

REQUESTS MUST BE ACCOMPANIED BY CORRESPONDENCE CONTAINING RELEVANT CLINICAL DETAILS.

- | | |
|--|---|
| <input type="checkbox"/> Chronic obstructive pulmonary disease | <u>Other relevant medical history:</u> |
| <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Interstitial lung disease | |
| <input type="checkbox"/> Neuromuscular disease | |
| <input type="checkbox"/> Ischaemic heart disease | |
| <input type="checkbox"/> Cardiac failure | |
| <input type="checkbox"/> Pulmonary hypertension | |
| <input type="checkbox"/> Neurological or cognitive disorder | |
| <input type="checkbox"/> Weight > 150kg | <input type="checkbox"/> Home O ₂ If yes, flow rate: |

MUST FULFIL THE SCREENING CRITERIA FOR SLEEP STUDY TO BE PERFORMED (Referrer to complete)

STOP-BANG Score: _____ (3 or more) **AND** ESS: _____ (8 or more)
 OR
 OSA50 Score: _____ (5 or more) **AND** ESS: _____ (8 or more)

If the person does not fulfil the screening criteria, refer to sleep specialist below for further evaluation.

- | | |
|---|--|
| Please tick one or both: | Referred to: Dr. M Ali Tahir |
| <input type="checkbox"/> Diagnostic Sleep Study | Priority: |
| AND/OR | <input type="checkbox"/> Standard |
| <input type="checkbox"/> Sleep Physician Consultation | <input type="checkbox"/> Urgent (specify reason) |

Referring Practitioner details: *(Stamp if available)*

Referrer: _____
 Provider number: _____
 Address (for results): _____ Date: _____
 _____ Signature: _____
 Contact number: _____

Hospital use only

- | | |
|---|---------------------------------|
| <input type="checkbox"/> Sleep Study only | |
| <input type="checkbox"/> Sleep Study followed by Consultation | Reviewed by Sleep Physician/AT: |
| <input type="checkbox"/> Consultation followed by Sleep Study | Date: |

Sleep and Respiratory Failure Service

Respiratory and Sleep Testing and Treatment, C2c, C-block, Nepean Hospital
 Phone: (02) 4734 1084 Fax: (02) 4734 1122

Email completed form to: NBMLHD-SleepService@health.nsw.gov.au



Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

NBMHR-0228A 030326

AMBULATORY SLEEP STUDY REQUEST NBMHR-0228



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	PHONE NO.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility: NEPEAN

AMBULATORY SLEEP STUDY REQUEST

STOP-BANG Sleep Apnoea Questionnaire

STOP

Do you snore loudly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel tired, fatigued or sleepy during daytime?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone observed you stop breathing or choking/gasping during your sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have or are you being treated for high blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No

BANG

BMI >35Kg/m ² ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Age > 50 years old?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neck circumference >40 cm?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gender: Male?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Total score

Epworth Sleepiness Scale

How likely do you doze off or fall asleep during the following situation? 0: would never doze; 1: slight chance of dozing; 2: moderate chance of dozing; 3: high chance of dozing

Situation	Score (0-3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total score	

OSA50

Questionnaire	Points
Waist circumference – Male >102cm or Female >88cm (3 points if yes)	
Has your snoring ever bothered other people? (3 points if yes)	
Has anyone noticed that you stop breathing or choking/gasping during your sleep? (2 points if yes)	
Are you aged 50 years or over? (2 points if yes)	
Total out of 10 points	

Holes Punched as per AS2828.1: 2019
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