HOME SLEEP STUDY REQUEST

Monash Health
246 Clayton Road, Clayton Vic 3168

Tel 9594 2280 or 9594 2836
Fax 9594 6080
Email sleepbooking@monashhealth.org

Patient Details *ALL fields must be completed.*

Name	Address	
DOB	Suburb	Postcode
Gender ☐ Male ☐ Female	Phone	
Email	Mobile	
Medicare #	Monash UR #	

Please complete the two questionnaires below to ensure the patient has a high probability for symptomatic moderate to severe obstructive sleep apnoea.

Epworth Sleepiness Scale *Please circle only one number per row - 0 = Never / 1 = Slight / 2 = Moderate / 3 = High*

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 (3 weeks to months). Even if you have not done some of these things recently, try to work out how they would have affected you.

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 talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Scoring: *add the value of all circled numbers - Total must be **8 or higher** to be eligible for direct referral for a home sleep study. Values below this will be referred for a Sleep Specialist Consultation first.*

TOTAL ______

OSA50 *Please circle only one number per row*

Obesity	Is your waist circumference >102cms (male) or >88cms (female)?	3
Snoring	Has your snoring ever bothered other people?	3
Apnoea	Has anyone noticed that you stopped breathing during sleep?	2
50	Are you aged 50 years or over?	2

Scoring: *add the value of all circled numbers - Total must be **5 or higher** to be eligible for direct referral for a home sleep study. Values below this will be referred for a Sleep Specialist Consultation first.*

TOTAL ______

Indication for Study *Ensure sufficient relevant Clinical History/ Study Indications / Specific Instructions*

Site ☐ Clayton

Priority ☐ Routine ☐ Urgent ☐ Cancellation List

Care Requirements *ALL questions MUST be answered. Patient must bring a carer if required.*

Does your patient require assistance with any day to day activities? ☐ Yes ☐ No If Yes, please specify: ______________

Does your patient require assistance walking a distance of 500 metres? ☐ Yes ☐ No ______________

Sleep Specialist Review *ONE option MUST be selected.*

☐	Option 1	Monash Sleep Specialist consultation PRIOR to sleep study
☐	Option 2	Monash Sleep Specialist consultation AFTER sleep study (Default Option)
☐	Option 3	Direct Sleep Study, follow up by referring specialist (patient to schedule with specialist)

Referrer Details *ALL fields MUST be completed*

Name			
Practice			
Provider #			
Phone		Date	

Signature ______________

OFFICE USE ONLY

Study	
Site	
Day	
Date	
Time	
Admin	

Scientist Approval	Name: ________ Date: / /	Physician Approval	Name: ________ Date: / /