



PH: 8001 7033  
**PLEASE EMAIL REFERRALS TO:** admin@breathewest.com.au  
**OR FAX ALL REFERRALS TO:** 9011 9671

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

\_\_\_\_\_ MEDICARE NO: \_\_\_\_\_

\_\_\_\_\_ PRIVATE HEALTH: YES  NO

REQUEST FOR: \_\_\_\_\_ CLINICAL NOTES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

REFERRING DOCTORS DETAILS: \_\_\_\_\_ COPIES TO: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DOCTORS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SLEEP ASSESSMENT	SLEEP STUDIES	RESPIRATORY ASSESSMENT	LUNG FUNCTION TESTS
URGENT (appt. within 7 Days) <input type="checkbox"/>	Home Based Polysomnography <input type="checkbox"/>	URGENT (appt. within 7 Days) <input type="checkbox"/>	Spirometry & Gas Transfer <input type="checkbox"/>
Commercial Vehicle Driver or Pilot <input type="checkbox"/>	In Laboratory Polysomnography <input type="checkbox"/>	Lung Nodule or Lung Mass <input type="checkbox"/>	Spirometry Without Gas Transfer <input type="checkbox"/>
Coronary Heart Disease <input type="checkbox"/>	Private Hospital <input type="checkbox"/>	Severe Respiratory Disease <input type="checkbox"/>	6 Minute Walk Test <input type="checkbox"/>
Cerebrovascular Accident <input type="checkbox"/>	Public Hospital <input type="checkbox"/>	NON URGENT <input type="checkbox"/>	Bronchoprovocation Test (Mannitol Challenge) <input type="checkbox"/>
Hypertension requiring $\geq$ 3 medications <input type="checkbox"/>	* To be considered for direct referral for a sleep study please complete the Epworth Sleepiness Scale and STOP BANG Form. MBS criteria requires ESS $\geq$ 8 and STOP BANG $\geq$ 4 to be eligible for direct referral for a sleep study.		
NON URGENT <input type="checkbox"/>			

STOP BANG QUESTIONNAIRE	Yes	No	EPWORTH SLEEPINESS SCALE
<b>1: SNORING</b> Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	<input type="checkbox"/>	<input type="checkbox"/>	How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling tired? This refers to your usual way of life in recent times.  <b>USE THE FOLLOWING SCALE TO CHOOSE THE MOST APPROPRIATE NUMBER FOR EACH SITUATION:</b> <b>0</b> - Would never doze <b>1</b> - Slight chance of dozing <b>2</b> - Moderate chance of dozing <b>3</b> - High chance of dozing  <b>SITUATION CHANCE OF DOZING</b>
<b>2: TIRED</b> Do you often feel tired, fatigued, or sleepy during daytime?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3: OBSERVED</b> Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>4: BLOOD PRESSURE</b> Do you have or are you being treated for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5: BMI</b> Is your BMI more than 35kg/m <sup>2</sup> ? (If unsure please leave blank)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>6: AGE</b> Are you over 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>7: NECK CIRCUMFERENCE</b> Is your neck circumference greater than 40cm?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>8: GENDER</b> Are you male?	<input type="checkbox"/>	<input type="checkbox"/>	
			<b>TOTAL SCORE</b>

Frances Chung, F.R.C.P.C.,  
 Anesthesiology 2008; 108:812-21 Copyright © 2008, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.