



A/Prof Jeremy Goldin MBBS FRACP (Director)
 Dr Chee Choy MBBS FRACP (Director)
 Dr Ashleigh Witt MBBS FRACP
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All correspondence to: 176 Heaths Rd Hoppers Crossing
 Phone: (03) 8001 7033 Fax: (03) 9011 9671
 Email: admin@breathewest.com.au
 We prefer to send and receive via Healthlink: westsabc

Referral Form

Patient name:	Gender:
DOB:	Address:
Ph:	
Medicare number:	

<u>Consultation</u>	<u>Sleep Studies</u>	<u>Respiratory Function Tests</u>
<input type="checkbox"/> Routine <input type="checkbox"/> Urgent Sleep <input type="checkbox"/> Commercial driver/pilot <input type="checkbox"/> IHD/CVA <input type="checkbox"/> HTN requiring >3 agents <input type="checkbox"/> Urgent Respiratory <input type="checkbox"/> Lung mass or nodule <input type="checkbox"/> Severe lung disease <input type="checkbox"/> Oxygen assessment	<input type="checkbox"/> Hospital Based Sleep Study (privately insured patients) <input type="checkbox"/> Home Based Sleep Study As per MBS 12250 requirements, only patients with ESS \geq 8 and STOPBANG \geq 3 can be referred direct for sleep study (please complete on next page). NOTE all direct referrals for sleep study require follow up appointment with a sleep physician to receive results and appropriate management.	Common Tests (Choose only 1) <input type="checkbox"/> Spirometry and gas transfer* <input type="checkbox"/> Spirometry without gas transfer* <input type="checkbox"/> Spirometry/FENO (for Asthma Assessment)* <input type="checkbox"/> Bronchoprovocation test (Mannitol Challenge) - additional fees apply Additional Tests (available for referral by respiratory physicians) <input type="checkbox"/> 6 minute walk test* <input type="checkbox"/> Plethysmographic Lung Volumes * <i>*these tests are bulk billed for Medicare eligible patients and indications Spirometry and gas transfer is the appropriate test for the vast majority of patients.</i>

Clinical notes:

Referring Doctor name:	Copy results to:
Provider number:	
Clinic/Address:	
Fax/Email for results:	
Signature:	



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STOPBANG QUESTIONNAIRE	Yes	No	EPWORTH SLEEPINESS SCALE	
1. SNORING 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? Use the following scale to choose the most appropriate number for each situation: 0 —Would never doze 1—Slight chance of dozing 2 —Moderate chance of dozing 3 —High chance of dozing	
2. TIRED Do you often feel tired, fatigued or sleepy during the daytime?	<input type="checkbox"/>	<input type="checkbox"/>		
3. OBSERVED Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	Situation	Chance of dozing
			Sitting and reading?	
4. BLOOD PRESSURE Do you have or are you being treated for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Watching TV?	
			Sitting, inactive in a public place (eg. a theatre or a meeting)?	
5. BMI Is your BMI more than 35kg/m ²	<input type="checkbox"/>	<input type="checkbox"/>	As a passenger in a car for an hour without a break?	
			Lying down to rest in the afternoon when circumstances permit	
6. AGE Are you over 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>	Sitting and talking to someone?	
			Sitting quietly after lunch without alcohol?	
7. NECK CIRCUMFERENCE Is your neck circumference > 40cm?	<input type="checkbox"/>	<input type="checkbox"/>	In a car, as the driver, while stopped for a few minutes in traffic?	
8. GENDER Are you male?	<input type="checkbox"/>	<input type="checkbox"/>	Total score	
<i>Frances Chung FRCPC</i> <i>Anaesthesiology 2008; 108:812-21 Copyright © 2008, the American Society of Anaesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.</i>				