Genesis Sleep Care

# SLEEP SERVICE REFERRAL

## PATIENT DETAILS

Name | Date of Birth | Gender ❑ M ❑ F

Address

Home Phone | Mobile

Email

❑ Uninsured ❑ Private Fund ❑ DVA

## PATIENT PRESENTATION *(Please Indicate)*

❑ Snoring
❑ Excessive Daytime Sleepiness
❑ Abnormal activity during sleep
❑ Apnoeas
❑ Hypertension
❑ Insomnia
❑ Narcolepsy
❑ Other
❑ Arrhythmia
❑ Diabetes Type 2
❑ BMI >30
❑ Congestive Heart Failure
❑ Nocturia
❑ Commercial driver

Clinical Notes

## INVESTIGATION REQUIRED

❑ Diagnostic Sleep Study - in hospital ❑ Home Sleep Study *(with Specialist Consultation)* ❑ CPAP Titration Study

❑ CPAP Pressure Review ❑ Sleep Study with Dental Device ❑ Other _____

## FOLLOW-UP

A Physician appointment will be arranged unless you prefer to review the patient yourself - Please indicate .....

❑ **Next available Specialist**

❑ **Urgent Assessment**

❑ **Opt out - review by GP**

❑ **Dr Vinod Aiyappan**
Adelaide Cardiology
St Andrew's Medical Centre
Level 2, 321 South Terrace
Adelaide SA 5000

❑ **Dr Vinod Aiyappan**
Adelaide Cardiology
313 Unley Road
Malvern SA 5061

❑ **Dr Shah Mohd Shif**
Adelaide Cardiology
979 North East Road
Modbury SA 5092

## REFERRING DOCTOR DETAILS *(Including Provider No.)*

**Please stamp/insert details:**

Signature: Date:

**Please forward your referral to:**

**Adelaide Cardiology**
**Ph: (08) 8202 6600 Fax: (08) 8202 6698**
**Email: info@adelaidecardiology.com.au**

**Thank you for your referral.**

**OFFICE USE ONLY**

Approved by: Date:

May 2016

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# PRACTICE NURSE SLEEP HEALTH ASSESSMENT

Date: _____

Patient Name: _____ DOB: _____

Have you ever had a sleep study? ❑ Yes ❑ No Are you currently on CPAP therapy? ❑ Yes ❑ No

**Please complete the following with the Practice Nurse.**

Height: _____cm Weight: _____kg BMI: _____

## STOP BANG QUESTIONNAIRE*

1. **Snoring**

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

❑ Yes ❑ No

2. **Tired**

Do you often feel tired, fatigued or sleepy during the day time?

❑ Yes ❑ No

3. **Observed**

Has anyone observed you stop breathing during your sleep?

❑ Yes ❑ No

4. **Blood Pressure**

Do you have or are you being treated for high blood pressure?

❑ Yes ❑ No

5. **BMI**

Is your BMI more than 35kg/m$^2$?

❑ Yes ❑ No

6. **Age**

Are you over 50 years of age?

❑ Yes ❑ No

7. **Neck Circumference**

Is your neck circumference greater than 40cm (≥Large)?

❑ Yes ❑ No

8. **Gender**

Are you male?

❑ Yes ❑ No

**High Risk of OSA: answering yes to three or more items**

**Low Risk of OSA: answering yes to less than three items**

## Nursing staff to complete referral form if indicated

Referral completed Tick yes ❑

Forwarded to GP for signature Tick yes ❑

*Adopted from:
STOP Questionnaire
A Tool to Screen Patients for Obstructive Sleep Apnoea
Chung et al


Phone **08 8202 6600** Fax **08 8202 6698**

**www.genesissleepcare.com.au** Email **info@adelaidecardiology.com.au**

May 2016

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