Sleep Management Services

Referral Form

Dr. Kevin Chan FRACP & Associates

Patient's name: _____ D.O.B: _____

Address: _____ Phone: _____

Email: _____ Gender: _____

Occupation: _____

Services requested: (please choose one or more)

☐ 1. Sleep / Respiratory Physician consultation – Consultation rates vary.
Medicare and DVA rates may apply. Private insurance rates may apply.

☐ 2. Unattended (ambulatory) diagnostic sleep assessment and management advice

☐ 3. Attended (In-lab) diagnostic sleep assessment (available in selective areas) and management advice

☐ 4. Non-Medicare diagnostic sleep assessment – fee to patient will apply

☐ 5. Ambulatory Holter 24hrs ECG Recording

Please kindly assist us by providing the following information if service 2 is chosen:

In accordance with the MBS, a Consultant Sleep Physician will assess the following information to determine whether the sleep study is eligible for a Medicare-rebate.

The criteria for eligibility include (but not limited to) a STOP Bang score of 4 or above and an Epworth Sleepiness Score of 8.

A. Does your patient have any of the following? (STOP Bang Questionnaire) *Please tick when applicable*

☐ Snoring loudly (e.g. enough to be heard through closed doors / affecting bed-partner's sleep)
☐ Tired, fatigued or sleepy during the wakeful hours
☐ Observed apnoeas or choking
☐ Being on treatment for hypertension (please specify_____)
☐ BMI > 35 (please specify _____)
☐ Age > 50 (please specify_____)
☐ Neck size (>= 43 cm for male and 41 cm for female: please specify _____)
☐ Male Gender.

B. How likely is your patient to doze off or fall asleep in the following situations, in contrast to feeling just tired? (Epworth Sleepiness score) Please score each
0 = would never doze / 1 = slight chance of dozing / 2 = moderate chance of dozing / 3 = high chance of dozing

__ Sitting and reading
__ Watching TV
__ Sitting, inactive in a public place (e.g. a theatre or a meeting)
__ 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

C. Medical Co-Morbidities (Please complete as appropriate)

☐ Hypertension ☐ Type 2 Diabetes ☐ AF ☐ Cardiac Failure ☐ Stroke/TIA ☐ COPD

Clinical History _____

_____

_____

_____

For this referral to be valid, please ensure the following details are completed:

Referring Dr. name _____ Provider No. _____

Practice name _____ Phone _____ Fax _____

Address _____

Email _____ ☐ Medical objects secure messaging

Referring Dr. signature: _____ Referral Date: _____

Please email the complete form to : referral@sleepmgt.com

or FAX: NSW: 02 8088 1165 ACT: 02 6169 3193 VIC: 03 8678 3228 QLD: 07 30090399

Our staff will contact the patient to book a convenient appointment.

For any enquiries, please contact 1300 801 835