# Breathe West

PH: 8001 7033
**PLEASE EMAIL REFERRALS TO:** admin@breathwest.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)** ☐ | Home Based Polysomnography ☐ | **URGENT (appt. within 7 Days)** ☐ | Spirometry & Gas Transfer ☐ |
| Commercial Vehicle Driver or Pilot ☐ | In Laboratory Polysomnography ☐ | Lung Nodule or Lung Mass ☐ | Spirometry Without Gas Transfer ☐ |
| Coronary Heart Disease ☐ | Private Hospital ☐ | Severe Respiratory Disease ☐ | 6 Minute Walk Test ☐ |
| Cerebrovascular Accident ☐ | Public Hospital ☐ | **NON URGENT** ☐ | Bronchoprovocation Test (Mannitol Challenge) ☐ |
| Hypertension requiring ⩾ 3 medications ☐ | * To be considered for direct referral for a sleep study please complete the Epworth Sleepiness Scale and STOP BANG Form. MBS criteria requires ESS ⩾ 8 and STOP BANG ⩾ 4 to be eligible for direct referral for a sleep study. | | |
| **NON URGENT** ☐ | | | |

| STOP BANG QUESTIONNAIRE | Yes | No |
|---|---|---|
| **1: SNORING** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? | ☐ | ☐ |
| **2: TIRED** Do you often feel tired, fatigued, or sleepy during daytime? | ☐ | ☐ |
| **3: OBSERVED** Has anyone observed you stop breathing during your sleep? | ☐ | ☐ |
| **4: BLOOD PRESSURE** Do you have or are you being treated for high blood pressure? | ☐ | ☐ |
| **5: BMI** Is your BMI more than 35kg/m$^2$? (If unsure please leave blank) | ☐ | ☐ |
| **6: AGE** Are you over 50 years old? | ☐ | ☐ |
| **7: NECK CIRCUMFERENCE** Is your neck circumference greater than 40cm? | ☐ | ☐ |
| **8: GENDER** Are you male? | ☐ | ☐ |

| EPWORTH SLEEPINESS SCALE | |
|---|---|
| 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. | |
| **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* |
| **SITUATION CHANCE OF DOZING** | |
| Sitting and reading? | |
| Watching TV? | |
| Sitting, inactive in a public place (eg. 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 persist? | |
| Sitting and talking to someone? | |
| Sitting quietly after a lunch without alcohol? | |
| In a car, as the driver, while stopped for a few minutes in traffic? | |
| **TOTAL SCORE** | |

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