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*Sleep Medicine & Respiratory Physician*



**SLEEP & RESPIRATORY TESTING REQUEST FORM**

 **STEP 1 REFERRAL FOR**

 **SLEEP** *(Choose an option)* **→** [ ]  **IN-CLINIC SLEEP STUDY** *(Level 1)*[ ]  **HOME SLEEP STUDY** *(Level 2)*

[ ]  **CPAP TITRATION** [ ]  **CPAP REASSESSMENT** [ ]  **CPAP TRIAL**

 **RESPIRATORY →** [ ]  **FULL LUNG FUNCTION TESTING**

 **STEP 2 PATIENT**

[ ]  **MALE FULL NAME**

[ ]  **FEMALE DOB CONTACT NUMBER**

 **ADDRESS**

 [ ]  **Medicare** [ ]  **Private** [ ]  **DVA** [ ]  **Commercial or licensing purpose**

 **STEP 3 LOCATION:** Please note Respiratory Testing is performed at our Meadowbrook clinic only

[ ]  **BRISBANE** [ ]  **SUNSHINE COAST** [ ]  **GOLD COAST** [ ]  **TOWNSVILLE**

 **BULK BILLING REQUIREMENTS FOR SLEEP STUDIES** **STEP 4: A score of ≥ 5 points + STEP 5: A score of ≥ 8 points**

 **STEP 4 INDICATION/S**

 **SLEEP →**  [ ]  **WITNESSED APNEA 2 points** [ ]  **SNORING 3 points** [ ]  **OVER 50 2 points** [ ]  **HYPERTENSION** [ ]  **DIABETES**

[ ]  **OBESITY (Waist: Male >102cm, Female >88cm) 3 points** [ ]  **OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **RESPIRATORY → CLINICAL INDICATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **CURRENT TREATMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **STEP 5 ESS (Epworth Sleepiness Scale)**: Not applicable if request form is for Respiratory Testing only

**How likely is the patient to doze or fall asleep in the following situations, in contrast to feeling just tired?**

**⓿= No Chance**

**❶= Slight Chance**

**❷= Moderate Chance**

**❸= High Chance**

 **⓿**[ ]  **❶**[ ]  **❷**[ ]  **❸**[ ]

**SITTING AND READING**

**WATCHING TV**

**SITTING INACTIVE IN A PUBLIC PLACE**

**AS A PASSENGER IN A CAR FOR AN HOUR WITH NO BREAK**

**LYING DOWN IN THE AFTERNOON**

**SITTING AND TALKING TO SOMEONE**

**SITTING QUIETLY AFTER LUNCH (WITHOUT ALCOHOL)**

**STOPPING IN TRAFFIC FOR A FEW MINUTES WHILE DRIVING A CAR**

 **⓿**[ ]  **❶**[ ]  **❷**[ ]  **❸**[ ]

 **⓿**[ ]  **❶**[ ]  **❷**[ ]  **❸**[ ]

 **⓿**[ ]  **❶**[ ]  **❷**[ ]  **❸**[ ]

 **⓿**[ ]  **❶**[ ]  **❷**[ ]  **❸**[ ]

 **⓿**[ ]  **❶**[ ]  **❷**[ ]  **❸**[ ]

 **⓿**[ ]  **❶**[ ]  **❷**[ ]  **❸**[ ]

 **⓿**[ ]  **❶**[ ]  **❷**[ ]  **❸**[ ]

 **STEP 6 REFERRING DOCTOR**

**FULL NAME**

**PRACTICE**

**PROVIDER NO.**

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE**

 **STEP 7 REPORT REQUIREMENTS**

[ ]  **Urgent** [ ]  **Medical Objects**

[ ]  **Standard** [ ]  **Fax**

**Please send Request Form via FAX (07) 3112 4107 or Medical Objects**

ABN 62 661 143 040