**1300 743 782 (SIESTA) Fax: (07) 3112 4107**

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Dr Geoffrey Williams Provider No. 408456W

*Sleep Medicine & Respiratory Physician*

Logo, company name

Description automatically generated

**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