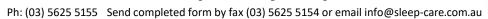
Home Based Sleep Study Request Form





Client Name					Gende	<u>r</u>		Mobile Phon	e		
Address)		Postcode	Postcode		
Medicare/DVA Number						nce N	umber	Expiry	Expiry		
Date of birth Neck Circumfer			mference		Height (cm)			Weight (kg)	Weight (kg) BMI		
Clinical Information											
Atrial Fibrillation Hypertension		Diabetes COPD			diac Failu ression	ire		Stroke/TIA Other			
STOP-BANG Question	nnaire				OR		OSA 50				
Do you Snore loudly? Do you often feel tired, fatigued, or sleepy during the daytime? Has anyone observed you stop breathing during your sleep? Do you have or are you being treated for high blood pressure? Do you have a BMI of more than 35kg/m2? Are you over the age of 50? Do you have a neck circumference greater than 40cm? Are you male? A total score of 3 or more is needed for Medicare subsidies							Waist circumference of 3 Male>102cm or Females >88cm Has your snoring ever bothered 3 other people? Has anyone noticed that you stop 2 breathing during your sleep? Are you over 50 years old? 2 A total score of 5 or more is needed for Medicare Subsidies				
EPWORTH SLEEPINES	SS SCALE	E (ESS) Compu	ulsory	Would n	ever	_	t chance	Moderate chance	0	chance	
Sitting and reading Watching TV Sitting, inactive in a public place As a passenger in a car for an hour without a break				doze (0)			ozing (1)	of dozing (2)	of dozing (3)		
Lying down to rest in the afternoon (when possible) Sitting and chatting to someone In the car stopped in traffic for a few minutes											
A total score of 8 or	more is ı	needed for N	ledicare s	ubsidies							
Doctor's Name	Pł	none		ı	Fax	(Or Stamp he	re (if available)			
Provider number	Cl	inic Address		I	Date						
Signature											