Synergy Sleep
BETTER THAN THE REST

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Sleep Study Referral

PATIENT DETAILS

Patient Name:	D.O.B:	Referral Date:
Address:	Medicare No.:	Exp Date:
BMI (Mandatory):	Phone:	Gender: ☐ M ☐ F ☐ Other

SLEEP SERVICE REQUIRED

☑ Level 2 Home Based Diagnostic Sleep Study
All subsidised studies must meet the approved criteria below in accordance with Medicare item 12250

REASONS FOR REFERRAL

ESS QUESTIONNAIRE
(for Medicare Bulk Billing, a patient must score 8 or more on the following)

TOTAL SCORE: /24

How likely are you to doze off in the following situations?	Slight	Moderate	High
Sitting and reading	☐ 1	☐ 2	☐ 3
Watching Television	☐ 1	☐ 2	☐ 3
Sitting inactive, in a public space	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without a break	☐ 1	☐ 2	☐ 3
As a driver, while stopped for a few minutes	☐ 1	☐ 2	☐ 3

OSA50 (for Medicare Bulk Billing, a patient must score 5 or more on the following)

TOTAL SCORE: /10

Obesity	Waist circumference Male >102cm, Female >88cm (measured at the umbilicus) ____ cm	☐ 3
Snoring	Has your snoring bothered other people?	☐ 3
Apnoea	Has anyone noticed that you stop breathing during your sleep?	☐ 2
50	Are you aged over 50 years?	☐ 2

REFERRING DOCTOR

Referring Doctor:	Practice Name:	Provider No.:
Dr. Signature:	Phone:	☐ Medical Objects Secure Messaging