REFERRAL FORM

Please send your referral to us by Fax: 1800 317 339 or via secure messaging

Our staff will contact the patient to book an appointment. Patients: Please bring this referral to your appointment.

Full name _____ DOB _____

Email _____ Phone / Mob _____ Commercial drivers licence Yes No

Request for a Referral *(Please mark appropriate options)*

Home sleep study - *This referral covers both a Home Sleep Study, and if required, sleep physician consultation*

CPAP/APAP trial for the treatment of sleep apnea

Mandibular advancement oral device for the treatment of snoring and sleep apnea

CPAP therapy review (pressure, compliance, mask review & full equipment check)

Supply of DVA approved equipment and services

Both OSA 50 AND ESS scores must be completed to qualify for a Medicare rebatted Home Sleep Study (Medicare item 12250)

Both ESS and OSA-50 questionnaires must be completed

ESS Questionnaire - *Patient must **score 8** or more.*

How likely are you to doze off (fall asleep) in the following situations?

Use the following scale to choose the most appropriate answer:

0 - No chance
1 - Slight chance
2 - Moderate chance
3 - High chance

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive, in a public space	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total score:

OSA-50 Screening Questionnaire - *Patient must **score 5** or more.*

Waist circumference (Measure at the level of the umbilicus)

Male > 102cm | Females > 88cm	Yes	**(3 points)**
Has your snoring ever bothered other people?	Yes	**(3 points)**
Has anyone noticed you stop breathing during your sleep?	Yes	**(2 points)**
Are you aged 50 years or over?	Yes	**(2 points)**

Total score:

Symptoms and medical conditions

Hypertension
Cardiac failure
Stroke / TIA
COPD
Other: _____

Overweight
Pacemaker
Type II Diabetes
Atrial fibrillation

Family history (OSA)
Clinical history
(optional, attach notes to this referral)

For a referral to be valid, please ensure the following details are completed and SIGNED

Referring Dr. name _____ Practice name _____

Provider no. _____ Address _____

Email _____ Phone _____ Fax _____

Referring Dr. signature: _____ Referral date _____

Communication via secure e-messaging preferred

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Approved DVA Supplier

Providing CPAP equipment for eligible DVA clients.

Please send your referral to us by

Fax: 1800 317 339 or via secure messaging

For support or general inquires call:

1800 737 633 (ResMed) or
Email: info@resmed.com.au

For more information, online bookings, more sleep related products or to find your nearest ResMed store visit:

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