



SOUTHERN[®]

RESPIRATORY & SLEEP SPECIALISTS

Southernrespiratorysleep.com.au

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Patient Details

Name: **Gender:** Male Female
Address: **Medicare No:**
DOB: **DVA No:**
Phone: **Concession No:**
Email: **Card Expiry:**

Co-morbidities

Sleep Apnoea Cardiovascular Disease
 Hypertension Stroke
 Diabetes Atrial Fibrillation

Symptoms

Snoring Witnessed Apnoea
 Restless Legs Shortness of Breath
 Cough / Wheeze Daytime Sleepiness

Services

Sleep / Respiratory Consultation Diagnostic Sleep Study CPAP Titration / Review Study
 Spirometry / Lung Function Test Rhinomanometry CPAP Therapy / Follow Up

ESS Questionnaire

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate score.

0 = Would never doze, 1 = Slight chance of dozing
 2 = Moderate chance of dozing 3 = High chance of dozing

Circle one score for each

Situation	Chance of Dozing (0-3)			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theatre)	0	1	2	3
As a passenger in a car for an hour without a break	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
In a car, while stopped for a few minutes in the traffic	0	1	2	3

TOTAL SCORE

Stop Bang Questionnaire

PLEASE TICK each situation:

S - Does the patient snore loudly?
 T - Does the patient often feel tired, fatigued or sleepy during the daytime?
 O - Has anyone observed the patient stop breathing during sleep?
 P - Does the patient have, or is the patient being treated for high blood pressure?
 B - Does the patient have a BMI more than 35?
 A - Age over 50 years old
 N - Neck circumference more than 40cm?
 G - Gender - Is the patient a Male?

TOTAL SCORE

Medicare guidelines require patient screening to determining the most appropriate test/consultation. Direct testing may be appropriate if the patient has high risk for moderate-severe OSA: ESS score of ≥ 8 and a score of ≥ 4 on a validated STOP BANG questionnaire.

Referring Doctor

Name:
Provider No:
Phone:
Fax:
Address:
Signature:
Date:

Stamp

Please Fax Referral to (02) 4252 7334