



## Home Sleep Study Questionnaire

Please submit with a completed Referral Form to [admin@respiratoryservice.com.au](mailto:admin@respiratoryservice.com.au)

The following information **MUST** be completed in order to assess a patient's eligibility for a direct at home sleep study as indicated by current regulatory guidelines.

MBS will only fund a Home Sleep Study if STOP BANG  $\geq 3$  and ESS  $\geq 8$ , otherwise a consultation with an RSS Sleep Physician will be necessary before a MBS funded sleep study can be approved. MBS will only allow funding of a Home Sleep Study (item No.12250) once every twelve months.

### Patient Details

Name:

Gender: M / F / Other

DOB:

Contact No:

Address:

### Referring Doctor

Name:

Contact No:

Address:

Provider No:

Signature:

Date:

### Sleep Services

☐ Specialist Consultations

☐ and/or Sleep Study

### Medical Conditions

### STOP-BANG Questionnaire

		Yes	No
1. Snoring:	Do you snore loudly (Louder than talking or loud enough to be heard through closed doors)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Tired:	Do you often feel tired, fatigued, or sleepy during daytime?	<input type="checkbox"/>	<input type="checkbox"/>
3. Observed:	Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
4. blood Pressure:	Do you have or are you being treated for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
5. BMI:	Is your BMI more than 35kg/m <sup>2</sup> ?	<input type="checkbox"/>	<input type="checkbox"/>
6. Age:	Are you 50 years or older?	<input type="checkbox"/>	<input type="checkbox"/>
7. Neck:	Is your neck circumference greater than 40cm?	<input type="checkbox"/>	<input type="checkbox"/>
8. Gender:	Are you male?	<input type="checkbox"/>	<input type="checkbox"/>
Total:			

### The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Choose the most appropriate number for each situation by circling a number next to each question

Situation	0 Never doze	1 slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting, inactive in a public place (eg. theatre or a meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon when circumstances permit	0	1	2	3
6. Sitting talking to someone	0	1	2	3
7. Sitting quietly after a lunch without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3
Total:	/24			

Please ensure the following box is ticked and the referring doctor details are completed.  
The sleep study **MUST** be booked with this information.

☐ Respiratory & Sleep Service will arrange an appointment for my patient.