| UR NUMBER      |
|----------------|
| SURNAME        |
| GIVEN NAMES    |
| POSTAL ADDRESS |
| PHONE NUMBER   |
| DATE OF BIRTH  |

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| Department of Thoracic Medicine                    | SURNAME  |              |                  |  |
|--|--|--------------|------------------|--|
| ·  | GIVEN NAMES  |              |                  |  |
| REFERRAL IN-LAB<br>SLEEP STUDY (Generic)           | POSTAL ADDRESS   |              |                  |  |
| Phone (03) 9788 1705                               | PHONE NUMBER   |              |                  |  |
| Fax: (03) 9125 8487                                | DATE OF BIRTH  |              |                  |  |
|  | DATE OF BIRTH  | rint Code:1  | 6172             |  |
| Referrer Details                                   |  |              |                  |  |
| Name of Referring Dr (print):                      | Date of Referral:/.  | /            |                  |  |
| Signature:   | Phone No:  |              |                  |  |
| Provider Number (mandatory)                        |  |              |                  |  |
| Referrals without a valid Medicare provider number |  |              |                  |  |
| Copies to:   |  |              |                  |  |
| OVERNIGHT ADMISSION Prob                           | <u>oable Diagnosis</u>   |              |                  |  |
| Type of overnight study:                           | ostructive Sleep Apnoea  | Sleep Physic | ian              |  |
| ☐ Diagnostic Study ☐ Ce                            | ☐ Central Sleep Apnoea ☐ Parasomnia/Insomnia                           |              | review suggested |  |
| CPAP Review (with own pump)                        | octurnal Hypoventilation   | pefore test  |                  |  |
| Pl   | _M / Restless Legs   |              |                  |  |
| Epworth Sleepiness Scale (ESS) (must be o          | completed by the referring doctor) =                                   | 1            |                  |  |
|  | nnaire (must be completed by the referring doctor)                     |              |                  |  |
| Do you spore loudly                                | (must be completed by the releming doctor)                             | Yes          |                  |  |
| 1 Shoring  | (louder than talking or loud enough to be heard through closed doors)? |              | No               |  |
| Tired Do you often feel tired                      | Do you often feel tired, fatigued, or sleepy during daytime?           |              | No               |  |
|  |  |              |                  |  |
| 3. <b>O</b> bserved Has anyone observed            | Has anyone observed you stop breathing during your sleep?              |              | No               |  |
| Blood  |  |              |                  |  |
| 4. <b>p</b> ressure Do you have or are yo          | u being treated for high blood pressure?                               | Yes          | No               |  |
| 5. <b>B</b> MI BMI more than 35 kg/i               | m²?  | Yes          | No               |  |
|  |  |              |                  |  |
| 6. <b>A</b> ge Age over 50 yr old?                 | Age over 50 yr old?  |              | No               |  |
| Neck   |  |              |                  |  |
| Neck circumference greater than 40 cm?             |  | Yes          | No               |  |
| 8. <b>G</b> ender Gender male?                     |  | Yes          | No               |  |
|  |  | 169          | 110              |  |
| Follow up in CPAP Clinic (During t                 | the day)   |              |                  |  |
| Type of appointment:                               | Referral to Sleep Apnoea Clinic: Yes                                   | No           |                  |  |
| Set up   | Attn: A/Prof David Langton   |              |                  |  |
| _ ,  | Department of Thoracic Medicine  |              |                  |  |
| CPAP pressure cm<br>as per CPAP study              | 1 120 01   |              |                  |  |
| Review   |  |              |                  |  |
|  | MUST BE FAXED TO (03) 9125 8487  |              |                  |  |

Peninsula Health
Sleep Laboratory & Clinic
A/Prof David Langton
Department of Thoracic Medicine

REFERRAL IN-LAB SLEEP STUDY (Generic) cont.

Phone (03) 9788 1705 Fax: (03) 9125 8487

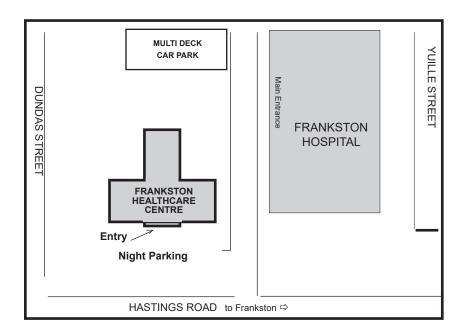
## Information Only Do Not Scan

## Where do I go?

The Sleep Unit is at the **Frankston Integrated Health Building**, on Hastings Road to the left of Frankston Hospital. The Sleep Laboratory is best accessed through the building's main **(front) entry**. To gain entry through the door after hours, you will need to use the intercom system (which is next to the key pad – on the right hand side of the main door) and speak to the scientist, who will come down to let you in. The laboratory is up on the first floor.

## Where can I park?

There is a multistory carpark behind the Integrated Health Building or for overnight admissions car parks may be used at the front of the Integrated Health Building



## For your test, please:

- bring all your medication
- bring your Medicare Card
- · bring pyjamas and any toiletries you may require
- wash body / hair
- shave under chin (if you have a beard)