Wangaratta Private Hospital
Part of Ramsay Health Care

NPE100090

BINDING MARGIN - DO NOT WRITE

Request For Sleep Study

URN: _____

Surname: _____

Given Name: _____

D.O.B: _____ Sex: _____

(Affix patient identification label here)

PATIENT

Name: ..... D.O.B: ...../...../.....

Phone: ..... Email: .....

Health Fund:..... Health Fund Number: | | | | | | | | | | |

Medicare Number: | | | | | | | | | | | MC Exp: | | | | | | MC Ref: |

ADMITTING PHYSICIAN

Name (print):

OR use stamp here

Signature: .....

Date of request: ...../...../.....

Date of review: ...../...../.....

PRIORITY

☐ **Routine PSG** ☐ **Urgent** (to be conducted within 2 weeks)

STUDY TYPE

☐ **Diagnostic [12203]: Unsuitable for home study, based on one or more of the following**

- ☐ Intellectual disability or cognitive impairment
- ☐ Significant relevant co-morbidities
- ☐ Suspected parasomnia or seizure disorder
- ☐ Failed or inconclusive unattented PSG
- ☐ Consumer preference
- ☐ Physical disability with inadequate carer attendance
- ☐ Suspected non-OSA sleep disorder
- ☐ Body position verification is essential
- ☐ Unsuitable home environment

☐ **CPAP Implement [12204]:**

Has the patient undergone CPAP in the previous 6 months? ☐ Yes ☐ No

Provide prescription: ☐ Emailed following analysis ☐ In the morning post-study ☐ No

☐ **Treatment Review [12205]: Select treatment mode & reason for test**

- ☐ CPAP ☐ APAP ☐ MAS
- ☐ Positional device ☐ Oxygen titration (provide instructions) ☐ Other: .....
- ☐ Recurrence of symptoms not explained by known or identifiable factors
- ☐ Significant weight or co-morbidity changes affecting SDB, where other efficacy assessment are unavailable or equivocal
- ☐ Clinical evidence of sub-optimal response or uncertainty about control of SDB

☐ **Repeat PAP Titration [12207]:**

☐ Previously failed CPAP or Oxygen studies ☐ To assess the effectiveness of a non-CPAP ventilatory support device

☐ **Repeat Diagnostic [12208]:**

Insufficient sleep (≤ 25 %) on a Diagnostic PSG in the last 12 months? ☐ Yes ☐ No

☐ **MSLT [12254]:** ☐ **MWT [12258]:**

Does the patient use treatment for SDB? ☐ No ☐ CPAP ☐ MAS ☐ Other: .....

(Treatment will be used during the overnight PSG & daytime MSLT unless otherwise instructed)

REASON FOR TEST / RELEVANT HISTORY / SPECIAL INSTRUCTIONS

(Please document below if the patient requires specific nursing or mobility assistance)

..... Estimated patient weight:..... kgs

.....

.....

.....

.....

OFFICE USE:	Date of study:

REQUEST FOR SLEEP STUDY

MR 0050

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BINDING MARGIN - DO NOT WRITE

REQUEST FOR SLEEP STUDY

MR 0050

BOOKING NOTES

Ensure to include date and staff initials

CLARIFICATION OF, DEVIATIONS FROM, OR ADDITIONS TO THE REFERRAL

If further information is required or if changes to the testing protocol need to be made, please contact the admitting physician for clarification and document that information here

Name: _____ Designation: _____

Signature: _____ Date: _____