Referral Form

Please send your referral to us via email.

Call: 0493308781 Email: info@somnowellhealth.com.au

A GP or Specialist will need to complete the Referring Practitioner Section for a Medicare rebate.

SOMNOWELL
SLEEP CLINIC

Patient Details					
Name				Gender	
Medicare number				DOB	
Email				Phone	
Address					
Age		Height (cm)		Weight (kg)	

Referring Doctor			
Name:		Provider No.:	
Address:			
Email:		Phone:	
Signature:		Date:	

Reason for Referral			
☐	Home Sleep Apnea Test	☐	Other: _____

Additional Information Relevant medical history (tick if applicable):					
☐	Hypertension	☐	Heart Disease	☐	Stroke
☐	Type II Diabetes	☐	Depression	☐	Reflux
☐	Bruxism	☐	TMJ Pain	☐	Other: _____

Please complete questionnaires on the reverse side

Epworth Sleepiness Scale (ESS)				
How likely are you to doze off in the following situations?	Never	Slight	Moderate	High
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped in traffic	☐ 0	☐ 1	☐ 2	☐ 3

Total ESS: ___ / 24

STOP-BANG Questionnaire			
	Item		Item
☐	Snore loudly (1pt)	☐	Often feel tired/sleepy (1pt)
☐	Observed stop breathing (1pt)	☐	High blood pressure (1pt)
☐	BMI > 35 kg/m^2? (1pt)	☐	Age > 50? (1pt)
☐	Neck circumference > 40 cm (1pt)	☐	Male gender (1pt)

Total STOP-BANG: ___ / 8

OSA50 Questionnaire			
	Item		Item
☐	Waist > 102 cm (M) / 88 cm (F) (3pts)	☐	Age > 50 (2pts)
☐	Snoring bothers others (3pts)	☐	Observed stops breathing (2pts)

Total OSA50: ___ / 10