

# Home sleep study request form



1300 732 695 | bocsleepcare@boc.com

## Patient details (all fields are mandatory)

To be completed by doctor

|                      |                      |   |
|----------------------|----------------------|---|
| Name                 | Phone                | Mobile  |
| <input type="text"/> | <input type="text"/> | <input type="text"/>  |
| Address              | Email                |   |
| <input type="text"/> | <input type="text"/> |   |
| Height               | Weight               | Date of birth   |
| <input type="text"/> | <input type="text"/> | <input type="text"/> / <input type="text"/> / <input type="text"/> (DD/MM/YYYY) |
| BMI                  | Neck Circumference   | Medicare/DVA number   |
| <input type="text"/> | <input type="text"/> | <input type="text"/>  |
|                      |                      | Reference number  |
|                      |                      | <input type="text"/>  |
|                      |                      | Expiry date   |
|                      |                      | <input type="text"/>  |
|                      |                      | Health insurance  |
|                      |                      | <input type="radio"/> Concession <input type="radio"/> Private                  |
|                      |                      | Commercial licence (if applicable)  |
|                      |                      | <input type="radio"/> Yes <input type="radio"/> No                              |
|                      |                      | Gender  |
|                      |                      | <input type="radio"/> Male <input type="radio"/> Female                         |

## Doctor's details

|                      |  |
|----------------------|--|
| Name                 | Signature  |
| <input type="text"/> | <input type="text"/>   |
| Address              | Date   |
| <input type="text"/> | <input type="text"/> / <input type="text"/> / <input type="text"/> |
| Phone                | Fax  |
| <input type="text"/> | <input type="text"/>   |
| Provider number      | Please stamp if available  |
| <input type="text"/> | <input type="text"/>   |
| Email                |  |
| <input type="text"/> |  |

## Comorbidities:

|   |                                |                                       |  |
|---|--------------------------------|---------------------------------------|--|
| <input type="radio"/> Atrial fibrillation | <input type="radio"/> Diabetes | <input type="radio"/> Stroke/TIA      | <input type="radio"/> Depression                 |
| <input type="radio"/> Hypertension        | <input type="radio"/> COPD     | <input type="radio"/> Cardiac failure | <input type="radio"/> Other <input type="text"/> |

## Please complete the following questionnaire on behalf of patient

### Sleep study type:

- Overnight home study  
 CPAP trial

### Other services:

- Physician consultation  
 CPAP equipment review

### Results required:

- Standard  Urgent  
 Email  Fax

## STOP-Bang (please tick)

|   |  |  |  |
|---|--|--|--|
| Do you snore loudly (louder than talking or can be heard through closed doors)? | <input type="radio"/> Yes <input type="radio"/> No | Has a BMI of more than 35kg/m <sup>2</sup> ? | <input type="radio"/> Yes <input type="radio"/> No |
| Do you often feel tired, fatigued, or sleepy during the daytime?                | <input type="radio"/> Yes <input type="radio"/> No | Are you over the age of 50?                  | <input type="radio"/> Yes <input type="radio"/> No |
| Has anyone observed you stop breathing during your sleep?                       | <input type="radio"/> Yes <input type="radio"/> No | Has a neck circumference greater than 40cm?  | <input type="radio"/> Yes <input type="radio"/> No |
| Do you have or are you being treated for high blood pressure?                   | <input type="radio"/> Yes <input type="radio"/> No | Are you male?                                | <input type="radio"/> Yes <input type="radio"/> No |

**NOTE:** Answering yes to four or more questions will support patient eligibility for a bulk billed sleep study to be conducted. Answering yes to three or less questions will require the patient to have a consultation with a Sleep Physician prior to conducting a bulk billed sleep study.

\*This field is mandatory

Risk level  High  Low

## Epworth Sleepiness Scale (ESS)

0 – Would never doze off 1 – Slight chance of dozing off 2 – Moderate chance of dozing off 3 – High chance of dozing off

|   |   |
|---|---|
| Sitting and reading   | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 |
| Watching TV   | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 |
| Sitting, inactive in a public place (e.g. a waiting room, a theatre or a meeting) | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 |
| As a passenger in a car for an hour without a break                               | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 |
| Lying down to rest in the afternoon when circumstances permit                     | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 |
| Sitting and talking to someone  | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 |
| Sitting quietly after lunch without alcohol                                       | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 |
| In a car, while stopped for a few minutes in traffic                              | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 |

**NOTE:** An ESS of seven or less requires a consultation with a Sleep Physician prior to conducting a bulk-billed sleep study.

Reference: STOP Questionnaire (Chung F et al. Anaesthesiology. May 2008; 108(5):812-21).

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Have your GP complete the Sleep Test Referral form  
and return it to one of the stores below.



**Boonah Pharmacy**  
**(07) 5463 1542**

82 High Street, Boonah QLD 4310

**Grange Road Pharmacy**  
**(07) 3281 6066**

82 Grange Road, Eastern Heights QLD 4305

**Raceview Pharmacy**  
**(07) 3281 8955**

Shops 1-4, Raceview Shopping Centre, 64 Raceview Street,  
Raceview QLD 4305

**Foote's Pharmacy Redbank Plains**  
**(07) 3814 3343**

Shop 62/63, Town Square Redbank Plains  
Redbank Plains Road, Redbank Plains Qld 4301

**Rosewood Pharmacy**  
**(07) 5464 1453**

Shop 6/40-46 John Street, Rosewood QLD 4340

We operate according to guidelines set by Medicare. Medicare will rebate for one portable or home study test in a twelve month period. If an abnormality is discovered from your portable or home study, you may require a second study based in a hospital Sleep Laboratory for an overnight sleep study. \*Details accurate as at 20/11/2018.