The Centre for Sleep & Pulmonary Medicine

REFERRAL FORM

PLEASE EMAIL OR FAX ALL REFERRALS

Dr Adrian Chazan MBBS MELB FRACP

Respiratory & Sleep Disorders Physician, General Physician

Main rooms & all correspondence to

269 Princes Hwy, Werribee VIC 3030 P 03 9191 4043 F 03 9017 8964 info@tcspm.com

Consulting at:

Werribee 269 Princes Hwy, Werribee
Williamstown 87 Ferguson St, Williamstown
Shepparton 96 Maude St, Shepparton

PATIENT DETAILS

Surname ____________ Given Name ____________

Address ____________ Suburb ______ State ______ Postcode ______

D.O.B. / / Phone ______ Mobile ______

Medicare # ____________ Private Health ☐ Yes ☐ No

REFERRING DOCTOR

Name ____________ Provider No. ____________

Address ____________ Suburb ______ State ______ Postcode ______

Copies to ____________

Doctor's Signature ____________ Date ____________

OUR SERVICES

Please tick one or multiple below as required

Sleep Studies

☐ Home sleep study ☐ Hospital sleep study

*For direct sleep study referrals please complete Epworth Sleepiness Scale (ESS) & STOP BANG questionnaire.
MBS Criteria for direct sleep study requires: ESS ≥ 8 & STOP BANG ≥ 4

Lung Function Test

☐ Spiro/DLCO ☐ Lung volumes (plethysmography) ☐ FeNO (exhaled nitric oxide)
☐ MIPS/MEPS ☐ Bronchial provocation testing ☐ FOT (airwave oscillometry)
☐ Six minute walk test / O_2 assessment

Specialist Consultation

☐ Respiratory ☐ Sleep

Tick the relevant option and please explain the nature of the clinical problem

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EPWORTH SLEEPINESS SCALE

Choose the most appropriate number for each situation:

0 - Would never Doze
1 - Slight chance of Dozing
2 - Moderate chance of Dozing
3 - High chance of Dozing

SITUATION	CHANCE OF DOZING (0-3)
1. Sitting and Reading	☐
2. Watching Television	☐
3. Sitting inactive in a public place (eg, a theatre or a meeting)	☐
4. As a passenger in a car for an hour without a break	☐
5. Lying down to rest in the afternoon when circumstances permit	☐
6. Sitting and talking to someone	☐
7. Sitting quietly after a lunch without alcohol	☐
8. In a car, while stopped for a few minutes in traffic	☐
TOTAL	______

STOP BANG Questionnaire

YES	NO	
☐	☐	**SNORING** *Do you snore loudly?*
☐	☐	**TIRED** *Do you often feel tired, fatigued, or sleepy during the day?*
☐	☐	**OBSERVED** *Has anyone observed you stop breathing during your sleep?*
☐	☐	**BLOOD PRESSURE** *Do you have or are you being treated for high blood pressure?*
☐	☐	**BMI** *Is your BMI more than 35kg/m2? If unsure please leave blank.*
☐	☐	**AGE** *Are you over 50 years old?*
☐	☐	**NECK CIRCUMFERENCE** *Is your neck circumference greater than 40cm?*
☐	☐	**GENDER** *Are you male?*

TOTAL ______