La Trobe Private Hospital

Cnr Kingsbury Drive & Plenty Road
BUNDOORA, VIC 3083

NORTHERN SLEEP LABORATORY

P: 9473 8956 **F:** 9471 1352
E: bookings@northernsleeplaboratory.com.au

Patient Details

Surname		Given Name	
Address		Ph (H)	
		Mobile	
Gender	☐ M ☐ F	Date of Birth	D D M M Y Y

Does the patient have private health insurance? ☐ Y ☐ N

Thank you for considering the above patient for an overnight diagnostic sleep study

Patient Statistics

Height (cm)		Blood pressure (mmHg)	
Weight (kg)		Currently on anti-hypertensives?	☐ Y ☐ N
Neck Circumference (cm)		(Estimate measurements if necessary)	

The patient reports the following symptoms

- ☐ Snoring
- ☐ Witnessed apnoeas
- ☐ Insomnia
- ☐ Nocturia
- ☐ Unrefreshed sleep
- ☐ Daytime sleepiness (complete ESS below)
- ☐ Restless legs

The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Choose the most appropriate number for each situation by putting an ☒ in one box for each question.

Situation:	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
1. Sitting and reading	☐	☐	☐	☐
2. Watching TV	☐	☐	☐	☐
3. Sitting, inactive in a public place (eg. 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	☐	☐	☐	☐

Additional Comments:

Please ensure the following box is ticked and the referring doctor details are completed. The sleep study cannot be booked without this information.

☐ I would like Northern Sleep Laboratory to arrange an appointment for my patient with the reporting sleep physician to discuss the result & arrange further management as indicated. (By ticking this box you are referring the patient for a period of 12 months unless otherwise specified)

Doctors Name:		Provider Number:	
Address: Report / letter will be sent to this location			
Signature:		Date:	

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Sleep study approved:	☐ Y ☐ N	Approved by:	
Location:		Study date:	

PLEASE FAX OR EMAIL THIS COMPLETED FORM DIRECTLY TO THE NORTHERN SLEEP LABORATORY

REQUEST FOR A DIAGNOSTIC SLEEP STUDY