RSDC Locations:

Ferntree Gully
Wantirna
Balwyn

Phone: 1300 7732 10
Fax: 1300 7732 20
Website: www.RSDC.com.au
Email: admin@RSDC.com.au

Home-Based Sleep Study Referral Form

Patient details or label:

Name:

DOB:

Phone:

Symptoms:

- ☐ Snoring
- ☐ Witnessed Apnoea
- ☐ Excessive Daytime Sleepiness
- ☐ Waking Unrefreshed
- ☐ Nocturia
- ☐ Morning headache
- ☐ High STOP-BANG

Other Medical Conditions:

- ☐ Neurologic / Stroke / TIA
- ☐ Cardiac Failure / AF / AMI
- ☐ Diabetes Mellitus
- ☐ Hypertension
- ☐ Obesity
- ☐ COPD
- ☐ Psychiatric Disorder
- ☐ Preoperative Assessment
- ☐ Other

Referring doctor:	**Date:**
Provider No:	**Signature:**
CC:	

STOP-BANG Questionnaire

☐ Yes ☐ No **Snoring?**
Do you Snore Loudly (loud enough to be heard through closed doors or your bed-parts elbows you for snoring at night)?

☐ Yes ☐ No **Tired?**
Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving or talking to someone)?

☐ Yes ☐ No **Observed?**
Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep?

☐ Yes ☐ No **Pressure?**
Do you have or are being treated for High Blood Pressure?

☐ Yes ☐ No **Body?**
Body Mass Index more than 35 kg/m^2?

☐ Yes ☐ No **Age?**
Age older than 50 year old?

☐ Yes ☐ No **Neck?**
Neck size large? (Measured around Adams apple) For male, is your shirt collar 17 inches/43 cm or larger? For female, is your shirt collar 16 inches/41 cm or larger?

☐ Yes ☐ No **Gender?**
Male?

Scoring Criteria:

For general population:

Low risk of OSA:	Yes to 0-2 questions
Medium risk of OSA:	Yes to 3-4 questions
High risk of OSA:	Yes to 5-8 questions