Health
South Western Sydney
Local Health District

Facility: Liverpool Hospital

POLYSOMNOGRAPHY REQUEST FORM

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SLEEP INVESTIGATION UNIT - Telephone (02) 8738 7470 Fax: (02) 8738 5350

Previous Sleep Study Details:

Where: _____

When: _____

Sleep Physician: _____

Relevant Clinical Information Attached:

☐ Clinical Letters/Notes ☐ Previous sleep study results

☐ Discharge Summary ☐ Other _____

Request Reviewed by LHSIU Specialist (internal use only)

Date: ____/____/20____

Specialist: _____

Review: ☐ Yes ☐ No

Pre-Test Diagnosis: _____

Urgency Code:

☐ Urgent (<2 weeks)
☐ High priority (<4 weeks)
☐ Normal priority
☐ Willing to be on cancellation list

Special needs:

☐ BMI ≥ 50 kg/m^2 If Yes, BMI = _____ kg/m^2
☐ Wheelchair bound
☐ 24 hour carer required
☐ Interpreter - Language _____

TEST REQUESTED

☐ Diagnostic study **(12203)**

Contraindication to unattended home sleep study (*select at least one*):

☐ Suspected sleep hypoventilation
☐ Suspected central sleep apnoea
☐ Presence of advanced respiratory/ cardiac/ neuromuscular disease
☐ Presence of acromegaly or hypothyroidism
☐ Suspected parasomnia
☐ Suspected seizure disorder
☐ Suspected sleep related movement disorder
☐ Unexplained hypersomnolence
☐ Intellectual disability or cognitive impairment
☐ Physical disability with inadequate carer attendance
☐ Consumer preference (anxiety regarding home sleep study, unreasonable cost/ disruption based on distance to be travelled, or unsuitable home circumstances)
☐ Previous failed or inconclusive home sleep study

Has this patient attended an in-laboratory diagnostic study in the previous 12 months which failed due to insufficient sleep, defined as sleep efficiency ≤ 25%? **(12208)**

☐ Yes (*attach study results*)

☐ No

☐ Diagnostic - unattended home sleep study **(12250)**

☐ CPAP titration **(12204)**

☐ Bi-Level PAP titration **(12204)**

☐ PAP review study **(12205)**
☐ CPAP review study
☐ Bi-Level PAP review study

(*Provide current PAP therapy details*)

☐ Treatment effectiveness (review) study **(12205)**
☐ Oral appliance
☐ Upper airway surgery
☐ >10% weight loss in previous 6 months
☐ Oxygen therapy
☐ Other _____ (*provide details*)

Additional requirements:

☐ ABG pm/am
☐ Transcutaneous CO_2
☐ Other _____

☐ MSLT **(12254)**

☐ MWT **(12258)**

Referring Doctor: _____

Address: _____ Provider Number: _____

Referral Date: ____/____/20____ Signature: _____

Insurance Status: ☐ Medicare ☐ Private Fund ☐ DVS ☐ Other: specify _____

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CR301.001