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 _____

SWS6081306 050220

POLYSOMNOGRAPHY REQUEST FORM
CR301.001

South Western Sydney Local Health District
Department of Sleep & Respiratory Medicine
Sleep Investigation Unit
Locked Bag 7103 Liverpool BC NSW 1871
Tel 02 8738 7470 Fax 02 8738 5350

SURNAME	MRN
OTHER NAMES	[ ] MALE [ ] FEMALE
DOB	MO
ADDRESS	

STOP-BANG QUESTIONNAIRE

Weight _____ kg
Height _____ cm
Body Mass Index _____ kg/m^2
Male/Female (please circle)
Age _____
Collar size of shirt: S, M, L, XL or ____inches/cm
Neck circumference _____ cm

1. Do you *s*nore loudly (louder than talking or loud enough to be heard through closed doors)?
Yes ☐ No ☐

2. Do you often feel *t*ired, fatigued, or sleepy during daytime?
Yes ☐ No ☐

3. Has anyone *o*bserved you stop breathing during your sleep?
Yes ☐ No ☐

4. Do you have or are you being treated for high blood *p*ressure?
Yes ☐ No ☐

5. *B*ody Mass Index more than 35 kg/m^2?
Yes ☐ No ☐

6. *A*ge over 50 year old?
Yes ☐ No ☐

7. *N*eck circumference greater than 40 cm?
Yes ☐ No ☐

8. *G*ender male?
Yes ☐ No ☐

Adapted from:
STOP Questionnaire
A Tool to Screen Patients for Obstructive Sleep Apnea
Chung et al., Anesthesiology 2008; 108:812-21

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EPWORTH SLEEPINESS SCALE

For each situation described below, indicate how likely you are to doze or sleep. If the situation just makes you feel tired, but doesn't make you doze or sleep, then it doesn't count.

Give answers that reflect your usual way of life in recent times. Even if you have not been in some of these situations recently, try to imagine how they would affect you.

Chance of Dozing

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Please circle one

Sitting and reading	**0 1 2 3**
Watching TV	**0 1 2 3**
Sitting inactive in a public place (e.g. a theatre or a meeting)	**0 1 2 3**
As a passenger in a car for an hour without a break	**0 1 2 3**
Lying down to rest in the afternoon when circumstances permit	**0 1 2 3**
Sitting down and talking to someone	**0 1 2 3**
Sitting quietly after lunch without alcohol	**0 1 2 3**
In a car while stopped for a few minutes in traffic	**0 1 2 3**

Total	____ / 24

Completed by patient? ☐ Completed by carer? ☐ Completed by interpreter? ☐

This sleepiness test is for information purposes only and should not replace a complete medical examination by a doctor. If you think you may have sleep apnoea or are worried about your health, please see your doctor.