



COASTAL

RESPIRATORY & SLEEP SPECIALISTS

Phone: (07) 5638 1259

Fax: (07) 5638 1274

Email: info@coastalrss.com.au

Website: www.coastalrespsleep.com.au

Tugun | Benowa | Southport | Pimpama

RESPIRATORY AND SLEEP REFERRAL

Patient Details

Name: _____ DoB: ____/____/____ Gender: M F
 Email: _____ Phone: _____
 Address: _____
 Medicare: DVA: Defence: Work Cover: Private Health Insurance: Yes None

Reason for Referral

- Respiratory Consult
- Sleep Consult
- Home Sleep Study (please refer to MBS criteria below)
 - + Sleep Consult
 - + Sleep Consult if recommended in report
 - + Sleep Consult if AHI > 30

Clinical Information

 Next Available Preferred Doctor: _____

Lung Function Testing

- Comprehensive Lung Function (spirometry, diffusing capacity, body plethysmography +/- bronchodilator)
- Spirometry & Diffusing Capacity
- Spirometry Pre & Post Bronchodilator

SLEEP STUDY

Important: To qualify for a direct Medicare subsidised home sleep study, your patient needs to score **3 or more on STOPBANG** and **8 or more on ESS**. If your patient does not qualify, please refer them for a **Sleep Consult PLUS Sleep Study**.

Patients must be 18 years or older for this service.

STOPBANG

Please tick if applicable: tick = 1

- Does the patient snore loudly?
- Does the patient feel tired during the day time?
- Has anyone observed the patient to have stopped breathing during sleep?
- Is the patient being treated for high blood pressure?
- Is the patient's BMI greater than 35?
- Is the patient's age 50 or older?
- Is the patient's neck circumference greater than 40cm?
- Is the patient's gender male?

Total: ____ / 8

EPWORTH SLEEPINESS SCALE (ESS)

How likely is the patient to doze off in the following scenarios:

	None (0)	Slight (1)	Mod (2)	High (3)
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting, inactive in a public place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being a passenger in a car for an hour without break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total: ____ / 24

Referrer Details

Name: _____ Date: ____/____/____
 Provider No: _____ Signature: _____



Send referrals to: Email: info@coastalrss.com.au | Fax: (07) 5638 1274
Medical Objects: Coastal Respiratory and Sleep