

Home-based sleep study assessment and request form

Patient details:

First name: _____ Last name: _____

Date of birth: _____ Medicare number: _____ Ref. No. _____

Phone number: _____

Referring doctor: (DOCTOR TO COMPLETE)

Name: _____ Provider number: _____

Phone number: _____ Fax number: _____

Reason for referral: _____

Signature: _____ Date: _____

Patient measurements: (DOCTOR TO COMPLETE)

Height _____m Weight _____kg BMI _____kg/m² Neck circumference _____cm

Exclusion criteria (DOCTOR TO COMPLETE)

If any of the following apply, direct referral for a home sleep study is not appropriate and initial assessment by a medical sleep specialist is recommended.

Intellectual disability / cognitive impairment	
Uncontrolled psychiatric disorder	
Physical disability with inadequate carer attendance	
Neuromuscular disease	
Chest wall deformity	
BMI ≥ 45	
Significant respiratory disease	
History of heart failure	
On opiate or sedative drugs	
Alcohol abuse	
Sleep-related disorders other than obstructive sleep apnoea suspected*	
Seeking review of an intervention for obstructive sleep apnoea	
Previously failed or inconclusive home sleep study	
Unsuitable home environment	
Patient prefers laboratory sleep study	

*e.g. abnormal behaviours or movements during sleep

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A patient referred directly for a home sleep study (Item 12250) must fulfil Epworth Sleepiness Scale AND either STOP-Bang OR OSA 50 criteria below to be eligible for Medicare funding of the study.
Note: Only MBS-funded once in a 12-month period.

Epworth Sleepiness Scale

Situation	Chance of dozing / sleeping			
	Never	Slight	Mod.	High
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. theatre or meeting)	0	1	2	3
As a passenger in a car for one hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total out of 24: _____ (≥8 to qualify under MBS)

STOP-Bang Questionnaire

	Points
Do you Snore loudly (heard through a closed door)?	1
Do you feel Tired , fatigued or sleepy during the day?	1
Has anyone Observed you stop breathing during your sleep?	1
Do you have or are you being treated for high blood Pressure ?	1
Is the BMI greater than 35?	1
Aged 50 years or older?	1
Is the Neck circumference greater than 40cm?	1
Gender : male?	1

Total: _____ (≥3 to qualify under MBS)

OSA 50 Questionnaire

	Points
Obesity Waist circumference*: Male >102cm Female >88cm	3
Snoring Has your snoring ever bothered other people?	3
Apnoeas Has anyone noticed you stop breathing during your sleep?	2
50 Are you aged 50 years or older?	2

*Measured at level of umbilicus

Total: _____ (≥5 to qualify under MBS)

Sleep study set-up:

Sleep technician: _____

Date: _____ Start time: _____ Finish time: _____

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