

Sleep Study Referral**To: Dr Cheng Siew****Patient Name:**

Name:

Address:

Tel/Mob:

D.O.B:

Medicare No.

Line:

Height (cm)**Weight (kg)****Waist****Referral Date:****Referring Doctor:**

Name:

Provider No:

Signature:

OSA50 Screening Questionnaire

			Score if Yes
Obesity	Is your waist circumference - measured at the level of the umbilicus (navel) Male over 102cm <i>or</i> Female over 88cm ?	Yes / No	3
Snoring	Has your snoring ever bothered other people ?	Yes / No	3
Apnoeas	Has anyone noticed that you stop breathing during your sleep ?	Yes / No	2
50	Are you aged 50 years or over ?	Yes / No	2
OSA50 Score ≥ 5 required for approval		Total	

Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale and circle the most appropriate number for the situation.

Chance of dozing:	none	slight	moderate	high
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g a theater 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 and talking to someone	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
ESS Score >10 required for approval	Total			

Hypertension**Diabetes**

Other Medical History

Comments