

Dr Sasse HOME and SLEEP LABORATORY SLEEP STUDY SERVICE

Patient to complete please -

Surname:		DOB:		/	/
First Name:		Gender:		M	F
Address:		State:			
Suburb:		Postcode:			
Phone: Home		Work:		Mobile:	
Medicare No:		Weight			
Pension No:		Height			
Private Insurance**	Fund Name & M'ship No.	DVA No.		ES Score (see over) ____/24	

**Note - private health insurers rebate some hospital sleep studies but not home sleep studies.
Medicare will rebate some of the cost of a home study.

Referring Practitioner to complete please (tick)

Signs/Symptoms		Sleep Study Type	
<input type="checkbox"/>	Loud or incessant snoring	<input type="checkbox"/>	Home (unobserved) sleep study
<input type="checkbox"/>	Witnessed apnoeas	<input type="checkbox"/>	Sleep Laboratory (observed) sleep study
<input type="checkbox"/>	Nocturnal choking/gasping	<input type="checkbox"/>	Sleep Laboratory CPAP set-up/progress
<input type="checkbox"/>	Daytime Sleepiness: sedentary	<input type="checkbox"/>	(Implementation) sleep study
<input type="checkbox"/>	Daytime Sleepiness: driving	Conditions indicating urgency	
<input type="checkbox"/>	Awakens unrefreshed	<input type="checkbox"/>	Surgery with general anaesthetic
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Difficult to control hypertension
<input type="checkbox"/>	Suspected Sleep Disorder	<input type="checkbox"/>	Diabetes (type II) poorly controlled
<input type="checkbox"/>	Obstructive Sleep Apnoea	<input type="checkbox"/>	Heart failure/cardiac disease
<input type="checkbox"/>	PLMS/Restless Legs	<input type="checkbox"/>	Respiratory failure
<input type="checkbox"/>	Narcolepsy	<input type="checkbox"/>	Accident due to sleepiness
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Parasomnia (type):		

Medicare Requirement – Reason for Home Sleep Study

<input type="checkbox"/>	No private health insurance +/- immediacy required/long public wait list
<input type="checkbox"/>	No Sleep Physician/ Laboratory within reasonable time or distance

Other pertinent details

If patient requires a hospital sleep study please complete -

Preference for hospital study:	Public		Private	
Priority:	Urgent		Routine	

Referring Practitioner Details:

Name:	
Address:	
(or stamp)	
Provider No:	
Date:	

Email to accounts @drsasse.com.au Enquiries: (03) 5174 5901.
Sleep Study staff will contact patient to make arrangements.

All requests are subject to prior approval by reporting Sleep Physician per Medicare requirements.
Dr Sasse and the Sleep Lab hold full Accreditation from the Thoracic Society of Aust and New Zealand.

** EPWORTH SLEEPINESS SCORE

Please complete the following and write your score on the front page.

How likely are you to doze or fall asleep in the following situations during the day? If you don't normally do these activities, please indicate what you think would happen.

Chance of dozing: 0 = None
1= Slight
2 = Moderate
3 = High

☐ Sitting and reading

☐ Watching television

☐ Sitting, inactive in a public place (eg theatre, meeting, shopping centre)

☐ As a passenger in a car for an hour with no break

☐ Lying down to rest in the afternoon, if circumstances permit

☐ Sitting and talking to someone

☐ Sitting quietly after lunch without alcohol

☐ Driving a car while stopped for a few minutes in traffic

☐ **Total Epworth Sleepiness Score**

**Adapted from: Johns M. A new method for measuring daytime sleepiness: the Epworth sleepiness scale.
Sleep. 1991 Dec 14 (6): 540-545

CPAP PRESCRIPTION FORM

Patient's Name

• CPAP Manual Pressure :

• CPAP Automatic Pressure (default 4 – 15cm)

• Mask to fit

Doctors Name

Date



Phone: 1300 650 752