



Request for Sleep Study

Epping Private Hospital
Level 1,
230 Cooper Street
EPPING VIC 3076

Bookings and Enquiries

Fax: (03) 9454 9339

Tel: (03) 9422 0077

Email: bookings@eppingsleeplaboratory.com.au

Patient Details

Name:
DOB:
Address:

Mobile:
Telephone:
Medicare No.:

Expiry: Ref No.:

Private Insurance:

Member Number:

Requesting Physician

Name:
Provider Number:
Date of Referral:
Address (*Report will be sent to this location*):

Please tick one:

Requesting Physician to report study

Laboratory Physician to report study

Referring Doctor (*if different to above*):

Address:

Study Type:

- Diagnostic
- Repeat Diagnostic: Was sleep efficiency $\leq 25\%$ on previous investigation Yes
- CPAP implement : Has the patient used CPAP therapy in the past 6 months No
- CPAP treatment review: Tick one or more
 - Symptoms recurrence Unable to assess treatment efficacy using other means
 - Pump download data is not useful Significant change in weight more than 10%
 - Significant changes in co-morbidities
- Treatment review study :
 - MAS Positioning device Provent Other:
- APAP study Implement Treatment review
- Oxygen titration (Provide information below)

Relevant past medical history:

- Hypertension Diabetes Epilepsy IHD Asthma Depression CCF COPD Stroke
- Other:

Clinical notes/ Relevant History/ Special Instructions:

CPAP prescription required: Yes No

Special instructions:

Patient's current CPAP pressure is _____ cm H₂O, with _____ l/min O₂ via _____
Start at _____ cm H₂O, and titrate upwards/downwards to optimal pressure

Patient's weight and special needs:

Patient's weight: kg

Mobility assistance : No Yes

wheelchair 4WF Hoist transfer Other (please specify):

Other special needs (please specify):

MBS code : 12203 12204 12205 12254 12258

Requesting physician signature:

Date of Request:

Date of Review: