Request for Sleep Study

Northern Sleep Centre

Northpark Private Hospital
135 Plenty Road,
Cnr Greenhills Road,
BUNDOORA VIC 3083

Bookings and Enquiries
Fax: (03) 9454 9339
Tel: (03) 9422 0077
Email: bookings@northernsleepcentre.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: Only if sleep efficiency ≤ 25% on previous study in the last 12 month
☐ CPAP implement : Has the patient used CPAP therapy in the past 6 months ☐ Yes   ☐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: Details

☐ APAP study: ☐Implement   ☐PAP treatment review

☐ MSLT : Is patient on a treatment for SDB ☐Yes   ☐CPAP   ☐ Positional device
☐ MWT : Is patient on a treatment for SDB ☐No   ☐ Other : Details

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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

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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   ☐ 12208

Requesting physician signature: Date of Request:

Date of Review: