Request for Sleep Study

Northen Private Hospital
Cnr Osburn Place and
Norwell Street,
Epping VIC 3076

Bookings and Enquiries
Fax: (03) 9454 9339
Tel: (03) 9422 0077
Email: reception@sleepandlungcare.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

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 ☐ 12208

Requesting physician signature: Date of Request:

Date of Review: