Request for Sleep Study

Epping Sleep Laboratory

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 ≤ 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: