Epworth Sleep Unit referral form

Please select your preferred Epworth Sleep Unit location below.

☐ **Epworth Camberwell**
888 Toorak Road
Camberwell VIC 3124

☐ **Epworth Geelong**
1 Epworth Place
Waurn Ponds VIC 3216

☐ **Epworth Richmond**
89 Bridge Road
Richmond VIC 3121

Referral for consultation / sleep studies

With consultant: on at

OR
☐ Next available

Patient details

Surname: First name: DOB: / /

Address: Postcode:

Home phone: Mobile: Email:

Clinical notes

☐ Snoring ☐ Apnoea ☐ Restless legs

☐ Insomnia ☐ Excessive sleepiness ☐ Unrefreshing sleep

☐ Hypertension ☐ Type II diabetes ☐ Cardiac disease

To expedite the referral process, please complete the patient questionnaires below.

EPWORTH SLEEPINESS SCALE PATIENT QUESTIONNAIRE

How likely are you to doze off (fall asleep) in the following situations?
Use the following scale to choose the most appropriate answer

0 = No chance **1** = Slight chance **2** = Moderate chance **3** = High chance

	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive, in a public space	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐
TOTAL	0			=

OSA-50 PATIENT QUESTIONNAIRE

Waist circumference (Measure at the level of umbilicus) Male > 102cm | Females > 88cm	Yes ☐	3
Has your snoring ever bothered other people?	Yes ☐	3
Has anyone noticed you stop breathing during your sleep	Yes ☐	2
Are you aged 50 years or over?	Yes ☐	2
TOTAL		

Referring Doctor

Name: Provider no.:

Address:

Telephone: Fax: Email:

Signature: Date of referral: / /

Referral period

☐ 3 months ☐ 12 months ☐ Indefinite

For referrals to all sites:
Ph. 03 9805 4225 | F. 03 9805 4120 | E. sleepbookings@epworth.org.au
www.epworth.org.au/sleep

Epworth

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