



REFERRAL FORM

Please send your referral to us by Fax: 1800 317 339, Email: referrals@resmed.com.au or via secure messaging. Medical Object ID: SR50060012H or HealthLink ID: resmedss

Our staff will contact the patient to book an appointment. Patients: Please bring this referral to your appointment.

Full name	DOB		
Email	Phone	Commercial drivers licence	Yes No

Request for Referral (*Please mark appropriate option/s)

- Home sleep study
- CPAP/APAP trial *For the treatment of sleep apnea*
- CPAP therapy review *Equipment, usage and comfort settings review*
- Supply of DVA approved equipment and services

REQUEST TYPE
Urgent
Routine

Both ESS AND OSA 50 scores must be completed to qualify for a Medicare rebated Home Sleep Study (Medicare item 12250)

ESS Questionnaire - Patient must score 8 or more.

How likely are you to doze off (fall asleep) in the following situations?	No chance	Slight chance	Moderate chance	High chance
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive, in a public space	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Patient must score 8 or more in the ESS questionnaire to qualify for a Medicare rebate	Total ESS score:
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OSA-50 Screening Questionnaire - Patient must score 5 or more.

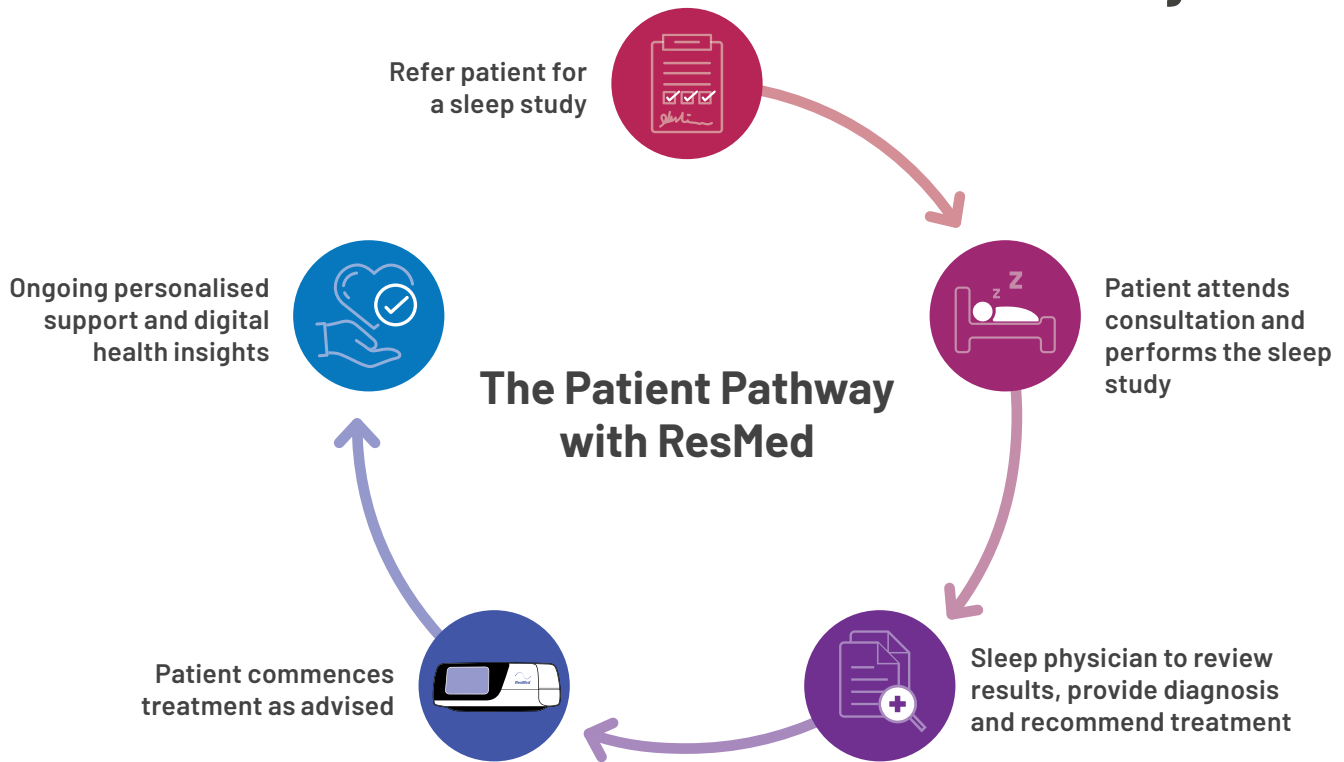
Waist circumference (Measure at the level of the umbilicus)	
Male > 102cm Female > 88cm	Yes (3 points)
Has your snoring ever bothered other people?	Yes (3 points)
Has anyone noticed you stop breathing during your sleep?	Yes (2 points)
Are you aged 50 years or over?	Yes (2 points)

Patient must score 5 or more in the OSA-50 questionnaire to qualify for a Medicare rebate	Total OSA-50 score:
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OPTIONAL	Medical conditions	Symptoms
	Hypertension Cardiac failure Stroke / TIA COPD Other: _____	Type II Diabetes Atrial fibrillation Obesity Family history (OSA) Other: _____
		Snoring Headache Restless sleep Irritability Other: _____
		Witnessed apneas / nocturnal gasping Insomnia Cognitive impairment Daytime lethargy / sleepiness Bruxism (teeth grinding) Driving fatigue

For a referral to be valid, please ensure the following details are completed and SIGNED

Referring doctor name	Practice name	
Provider no.	Address	
Email	Phone	Fax
Referring doctor signature:	Referral date	
Communication via secure e-messaging preferred		



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Approved DVA Supplier

Providing CPAP equipment for eligible Department of Veteran Affairs clients.



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For support or general inquiries

Phone: 1800 737 633 (ResMed)



Patients



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To book an appointment or for more information about sleep health, visit:

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Doctors



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