



# Hunter Respiratory and Sleep Centre

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## Referral Request

Please send your referral to us by Fax or Email or via Healthlink secure messaging.

Patient Details			
Name:		DOB:	
Contact:	Mobile:	Home:	Email:
Address:			
Clinical Priority			
Urgent (e.g. lung tumour, MVA due to sleepiness etc.) <a href="#">Please call us for an urgent appointment.</a>	<input type="checkbox"/>	Semi-urgent	<input type="checkbox"/>
		Routine	<input type="checkbox"/>
Respiratory Investigation (test only)		Sleep Investigation (test only)	
Pulmonary Function Testing (PFT) (Spirometry and Diffusion Capacity)	<input type="checkbox"/>	Diagnostic Sleep Study (Home/In-lab sleep study) <a href="#">Both OSA 50 AND ESS questionnaire on the back page must be completed to qualify for a Medicare rebate</a>	<input type="checkbox"/>
Lung Volume	<input type="checkbox"/>	CPAP/BiPAP Titration Study	<input type="checkbox"/>
Bronchial Provocation Test for Asthma <a href="#">Need PFT first (Contraindicated if FEV1&lt;70%)</a>	<input type="checkbox"/>	Dignostic Study and Day Sleep Latency (MSLT) <a href="#">Need sleep physician consult to qualify for Medicare rebate</a>	<input type="checkbox"/>
FENO (Assess Steriod Responsiveness)	<input type="checkbox"/>	Dignostic Study and Day Wakefulness Test (MWT) <a href="#">Need sleep physician consult to qualify for Medicare rebate</a>	<input type="checkbox"/>
Skin Allergy Test	<input type="checkbox"/>	Oximetry (non-Medicare rebate item)	<input type="checkbox"/>
MIPS/MEPS (Respiratory Muscle Testing)	<input type="checkbox"/>	CPAP/BiPAP/ASV trial and technician review	<input type="checkbox"/>
<b>Respiratory Consultation</b>	<input type="checkbox"/>	<b>Sleep Consultation</b>	<input type="checkbox"/>
Our team will contact patient for an appointment with our first available physician.			
Brief clinical history:			
Referring Doctor			
Name:		Provider number:	
Practice Address:			
Signature:		Date of Referral:	

Email Report:	Copy of Report to:
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**Medicare Rebate Screening Questionnaire for Sleep Study**

Please complete the following screening questionnaires with your patient. It is a Medicare requirement that a patient need to have **STOP BANG>3 or OSA 50>5 and ESS>8** to qualify for rebated sleep study without physician consultation. Alternatively, please tick a sleep consultation request and our friendly team will contact the patient to direct an appropriate pathway.

**OSA50 Screening Questionnaire (if Yes, please circle score)**

Obesity	Waist circumference Male>102cm or Females>88cm	Yes (3 points)
Snoring	Has your snoring ever bothered other people?	Yes (3 points)
Apnoea	Has anyone noticed that stop breathing during your sleep?	Yes (2 points)
50	Are you over 50 years old?	Yes (2 points)
Total Score:		

**Epworth Sleepiness Scale (Please circle your score)**

**How likely are you doze off or fall asleep in the following situations?** This refers to your usual way of life in recent times.

0 = would never doze off 1 = slight chance 2= moderate chance 3=high chance of dozing

Sitting and reading	0	1	2	3
Watching T.V	0	1	2	3
Sitting, inactive in a public place (e.g theatre, meeting)	0	1	2	3
As a passenger in a car for an hour without a break	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 lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3
Total Score:				

**Additional criteria for further assessment for in-lab sleep testing (Please ✓ if applicable)**

Intellectual disability or cognitive impairment	
Physical disability with inadequate care attendance	
Neuromuscular disorder	
Heart failure or suspected central sleep apnoea	
Suspected respiratory failure may require TCO2 monitoring	
Suspected parasomnia or sleep movement disorder or seizure disorder	
Suspected positional sleep apnoea and not recorded as part of unattended study	
Previously failed or inconclusive unattended study	
Unsuitable home environment including unsafe environments; and	
Consumer preference based on high level anxiety about location of study or where is unreasonable cost or disruption based on distance travel or home circumstances.	

**Please stop the following medications before pulmonary function test.**

Short acting bronchodilators (e.g, Ventolin, Asmol, Bricanyl).	Withhold for 6 hours
Long-acting bronchodilators (e.g, Seretide, Serevent, Flutiform)	Withhold for 12 hours or 48 hours for asthma test
Ultralong acting bronchodilators (e.g Onbrez, Spioloto, Ultibro, Anoro, Brimica, Breo, Trelegy, Trimbo, Breztri)	Withhold for 24 hours or 72 hours for asthma test
Oral non-steroid preventers (e.g, Singulair or montelukast)	Withhold for 72 hours for asthma test.
Oral antihistamines (e.g Telfast, Zyrtec, Loratadine)	Withhold for 5 days for asthma/allergy test