

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
Waurm 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	1	2	3	
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting inactive, in a public space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TOTAL	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	= <input type="text"/>

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

