


| | |
|--|---|
|  <p style="text-align: center;">Southern Adelaide Local Health Network</p> <p style="text-align: center;">SLEEP HEALTH SERVICE</p> <p style="text-align: center;">SLEEP & RESPIRATORY SPECIALIST REQUEST</p> <p style="text-align: center;">(MR591)</p> | <p style="text-align: center;">Affix patient identification label in this box</p> <p>UR No:</p> <p>Surname:</p> <p>Given Name:</p> <p>Second Given Name:</p> <p>D.O.B: Sex:</p> |
|--|---|

Once all fields have been completed, [send via fax to 8404 2333 or email to Health.SleepServices@sa.gov.au](mailto:Health.SleepServices@sa.gov.au)
 Booking enquiries phone: (08) 8404 2331 / Result enquiries phone: (08) 8204 6632

Referring Doctor Details (MANDATORY)

Name: Provider Number:

Address:

Date of referral: ___ / ___ / 20___ Copies to:

Triage Category:

Category 1 - Urgent (MVA / AF / resistant HT / ESS ≥ 14 / Commercial Driver)

Category 2 - (Required within 90 days)

Category 3 - (Greater than 90 days)

Reason for test:

Date of Study: ___ / ___ / 20___ **Date of follow up:** ___ / ___ / 20___

Clinic: FMC NGPP Private

Study Requirements:

| | | |
|---|---|---|
| <input type="checkbox"/> Home Based <input type="checkbox"/> Non nursing assistance required (<i>Patient Independent</i>) <input type="checkbox"/> High Pre-Test probability of OSA (<i>With no comorbidities</i>) <input type="checkbox"/> Can return equipment to FMC following day | <input type="checkbox"/> Lab Based (Level 2 FMC) <input type="checkbox"/> Suspected sleep disorder with <i>multiple comorbidities</i> <input type="checkbox"/> Under 18 (12—17 years) <input type="checkbox"/> Country Patient <input type="checkbox"/> Daytime Testing Required | <input type="checkbox"/> Ward Based (6A FMC) <input type="checkbox"/> Nursing support required (bed transfers, lifting, dressing, medication dispensing, continence management) <input type="checkbox"/> Acute NIV/CPAP <input type="checkbox"/> Unstable cardiac / respiratory disease <input type="checkbox"/> Advanced neuromuscular disease <input type="checkbox"/> Bariatric Bed (weight load 170kg) <input type="checkbox"/> Ward Oximetry <input type="checkbox"/> CPAP / <input type="checkbox"/> BiPAP (Choose One) <input type="checkbox"/> Apnoea Link <input type="checkbox"/> Ambulatory Ward Study |
| Note: Must meet all the above criteria | Note: Any of the above requires Lab Study | Note: Any of the above requires Ward Study |

Tests Requested

| | | |
|--|--|--|
| <input type="checkbox"/> Ambulatory Diagnostic Study <input type="checkbox"/> 1HR <input type="checkbox"/> 2HR <input type="checkbox"/> Home Autoset Titration (APAP) <input type="checkbox"/> Sleep Diary and Actigraphy <input type="checkbox"/> Apnoea Link <input type="checkbox"/> Home Oximetry <input type="checkbox"/> Mail out ApneaLink/Oximetry | <input type="checkbox"/> Diagnostic Study <input type="checkbox"/> CPAP Titration <input type="checkbox"/> Split if AHI > 20 <input type="checkbox"/> Split Therapy <input type="checkbox"/> MAS <input type="checkbox"/> Full Study / <input type="checkbox"/> Split (choose one) <input type="checkbox"/> Multiple Sleep Latency Test (MSLT) Diagnostic required night prior <input type="checkbox"/> Maintenance of Wakefulness Test (MWT) Diagnostic required night prior | <input type="checkbox"/> BiPAP Titration IPAP:..... EPAP:..... <input type="checkbox"/> S Mode <input type="checkbox"/> S/T Mode <input type="checkbox"/> T Mode (BPM) <input type="checkbox"/> ASV EPAP..... PSmin PSmax Details..... |
|--|--|--|

| | |
|---------------------------------|---|
| Relevant medical history | Care level required (MANDATORY) |
| | <input type="checkbox"/> Complex (discuss with manager) |
| | <input type="checkbox"/> Dependent (Carer to stay) |
| | <input type="checkbox"/> Independent (no nursing support) |

Additional Recordings / Requirements

| | | |
|---|---|--|
| <input type="checkbox"/> Video Monitoring <input type="checkbox"/> Extended EEG <input type="checkbox"/> Extended EMG | <input type="checkbox"/> Oxygen L/min <input type="checkbox"/> TcCO ₂ <input type="checkbox"/> ABG | <input type="checkbox"/> Interpreter Required, Specify |
| | | <input type="checkbox"/> VRE / MRSA / ESBL / Multi-resistant pseudomonas |
| | | <input type="checkbox"/> Other (specify) |

Approving / Reporting Specialist

| | | | | | |
|-----------------------------------|-------------------|--|--|--|----------|
| Full Name (<i>Please Print</i>) | Provider Number: | | | | |
| Address | | | | | |
| Signature | Date | | | | |
| | ___ / ___ / 20___ | | | | AM PM |

SLEEP HEALTH SERVICE REFERRAL / REQUEST

MR591