Referral Form

Please email your referral to
sleephealthtreatment@flinders.edu.au
We will contact your patient to schedule an appointment

AISH Sleep Health Clinic
Phone: 08 8432 4242
https://www.flinders.edu.au/fhmri/research/sleep-health/sleep-health-treatment

Flinders University

To arrange a physician review and/or appointments for insomnia and circadian management, please email this completed referral form to sleephealthtreatment@flinders.edu.au. In addition to this referral please also attached a Patient health summary and MHCP (where applicable). We recommend booking a **long consult** to provide sufficient time to complete the referral.

PLEASE NOTE, we are a **private clinic**, and co-payment is required per appointment. Please call or email our clinic for any questions regarding fees.

GP/SPECIALIST TO COMPLETE

Patient Details

First Name	Last Name	Gender	D.O.B.	
Address				
Email Address				
Phone (Mobile)	(Home)	Height (cm)	Weight (kg)	BMI
Medicare No.	IRN Exp.	DVA No.	Type Gold☐White☐Yellow ☐	

Sleep Services

If your patient does not score the minimum for a sleep study Medicare subsidy, we will arrange for a Sleep Physician consultation to determine test necessity and Medicare eligibility.

☐ Sleep Study		☐ Sleep Psychology (MHCP required for MBS rebates)	
Sleep Physician consult	☐First available	☐ Prof Robert Adams	☐ Dr Thomas Altree

*A Mental Health Care Plan MUST accompany this referral for patients to access MBS rebates under the Better Access initiative.

MBS, NDIS, DVA, private cover and out of pocket payment options available

Epworth Sleepiness Scale (ESS)

How likely are you to doze off in these situations?	Never	Slight	Moderate	High	
Sitting and reading	☐0	☐1	☐2	☐3	**TOTAL SCORE** ☐
Watching television	☐0	☐1	☐2	☐3	
Sitting inactive in a public place (e.g. a theatre or 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	Patient must score ≥ 8 for a Medicare subsidy
Sitting quietly after a lunch without alcohol	☐0	☐1	☐2	☐3	
In a car, while stopped for a few minutes in the traffic	☐0	☐1	☐2	☐3	

STOP-BANG questionnaire	Yes	No
Do you snore loudly?	☐1	☐0
Do you often feel tired, fatigued, or sleepy during the day time?	☐1	☐0
Has anyone observed you stop breathing during your sleep?	☐1	☐0
Do you have or are you being treated for high blood pressure?	☐1	☐0
Are you obese/very overweight – BMI more an 35kg/m2?	☐1	☐0
Age over 50 years old?	☐1	☐0
Neck circumference great than: 43cm (male) or 41cm (female)	☐1	☐0
Are you male?	☐1	☐0
TOTAL SCORE Patient must score ≥ 3 for Medicare subsidy	☐	

OR

OSA 50 screening questionnaire	Yes
Waist circumference Male >120cm / Female >88am	☐3
Has your snoring ever bothered other people?	☐3
Has anyone noticed you stop breathing during your sleep?	☐2
Are you aged 50 years or over?	☐2
TOTAL SCORE Patient must score ≥ 5 for Medicare subsidy	☐

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Preferred psychologist (if referring for psychology)	
☐ First available	☐ Preferred clinician (see website for our practicing psychologists)
Name of preferred clinician Preferred clinician	
Are any MHCP sessions currently used by another Psychologist? ☐ Yes ☐ No	If yes, how many?

Current Risk Assessment for Suicide and Self Harm
Date assessed
Details
Provision for interim care

For immediate concerns or high risk, please contact Mental Health Triage on 13 14 65 pr have the patient present to the local emergency department. We are not an acute service and cannot respond to immediate high risk.

Research trial participation
Is the patient currently involved/being referred as part of an AISH research trial? ☐Yes ☐ No
If yes, name of research trial (incl. SAPOL reconditioning or SAAS research):

PLEASE ENSURE A PATIENT HEALTH SUMMARY AND MHCP (if required) IS INCLUDED WITH THIS REFERRAL
The referral must be completed in entirety to be accepted. If not, it will be returned for completion.

Referring Doctor		
☐GP ☐Specialist	Date	Provider no.
Referring Doctor		Signature
Practice name		
Email address		Phone no.
Address		

PATIENT TO COMPLETE **Primary sleep complaint**		
☐ Sleep Apnoea (OSA)	☐ OSA treatment	☐ Restless legs
☐ Insomnia	☐ Parasomnia	☐ Shift work
☐ Daytime lethargy/sleepiness	☐ Other	
Do you have a CPAP machine? ☐ Yes ☐No	Have you had a recent sleep study? ☐ Yes ☐ No If yes, please attached a copy of your sleep study report to this referral	

Planned payment method				
☐ Medicare Rebates (co-payment required)	☐ Private Cover	☐ NDIS for plan and self-managed clients only (Patient to confirm eligibility)	☐ DVA	☐ Out-of-pocket