Mayo Private Hospital

SomnoScience
The Science of Healthy Sleep

SLEEP REFERRAL

(T) 02 6539 3600 (F) 02 6552 0059

Patient details

Name:_____

Address:_____

_____ Postcode:_____

Phone:_____

Mobile:_____

DOB:_____

(please tick)

Commercial Licence *(if applicable)*: ☐ Yes ☐ No

Gender: ☐ MALE ☐ FEMALE

Type of Study *(please tick)*

- ☐ Inpatient/Inlab sleep study
- ☐ Respiratory/sleep consultation
- ☐ CPAP Trial
- ☐ Titration review
- ☐ Home-based sleep study

Relevant Clinical History/Medications

(please complete)

_____

Doctor details

Name:_____

Address:_____

_____ Postcode:_____

Phone:_____

Fax:_____

Provider No:_____

Signature:_____

Office Stamp (if available)

Please complete on behalf of patient:

STOP Questionnaire *(please tick)*

Do you snore loudly (louder than talking/can be heard through a closed door)?	☐ Yes ☐ No
Do you often feel tired, fatigued or sleepy during the day?	☐ Yes ☐ No
Has anyone noticed you stop breathing during your sleep?	☐ Yes ☐ No
Do you have or are you being treated for high blood pressure?	☐ Yes ☐ No

Recommendations

Patients answering YES to 2 or more of the above questions are at high risk of having OSA and should be referred directly for a sleep study or consultation.

Patients answering YES to less than 2 questions should be referred to a sleep specialist consultation in order to determine the necessity for further investigation.

Reference: STOP Questionnaire (Chung F et al., Anaesthesiology, May 2008; 108(5):812–21).

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