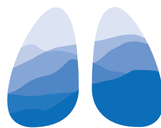


MEREDITH
RESPIRATORY AND SLEEP CENTRES
DR FREIBERG & ASSOCIATES

Book specialist consultation
PH. 9790 2378 | FAX. 9790 2185
E. reception@drdavidfreiberg.com.au
Book sleep study only
PH. 8405 7555 | FAX. 8405 7554
E. sleepinfo@drdavidfreiberg.com.au

PLEASE EMAIL OR FAX THE COMPLETED FORM

SECTION A Patient Details (Or Place Patient Label)

Patient Name ______ Gender: M ☐ F ☐ DOB: __ / __ /

Address ______ Phone: (02) ______

Mobile ______ Email ______

Next of Kin Name ______ Contact Number ______

Medicare Card Number ______ Ref ______ Expiry __ / __ /

Pension Card ☐ or Healthcare Card ☐ Number ______ Expiry __ / __ /

Private Health Fund Name ______ Membership Number ______

SECTION B Please select one of the following options:

1- ☐ **Physician Consultation**

Please select one of the following: ☐ Dr Freiberg ☐ Dr Syeda (Bankstown only)

2- ☐ **Sleep Study Only without Consultation** (Must fill out Section E overleaf and pass Medicare Criteria for eligibility)

3- ☐ **Respiratory Laboratory Only without Consultation**

- ☐ Spirometry
- ☐ Spirometry & FeNO2
- ☐ Detailed lung function
- ☐ Asthma Challenge test (Mannitol)
- ☐ Allergy Skin test

SECTION C Clinical Notes (Optional, attach notes to this referral)

SECTION D Referring Doctor Details (Can use stamp)

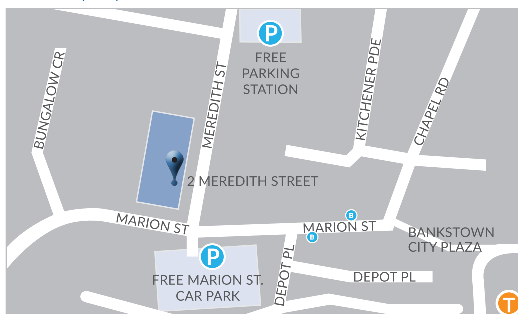
Name ______ Provider number ______ Specialist / GP ______

Address ______

Email ______ Phone number ______ Fax ______

Referring Doctor Signature ______ Date: __ / __ /

SUITE 4, L3, 2 MEREDITH ST. BANKSTOWN 2200



SECTION E (Please fill out this section IF ONLY a sleep study without consultation is requested in section B)

(The final score needs to reviewed and assessed by the Referring Doctor to decide Patient's eligibility)

Patient Name ______________________ Date of Birth: ___ / ___ / ______

EPWORTH SLEEPINESS SCALE

For a Medicare subsidised sleep study, a patient must score 8 or more on the following.

Total Score:

How likely are you to dose off In the following situations?

0 - Would **NEVER** doze
1 - **SLIGHT** chance of dozing
2 - **MODERATE** chance of dozing
3 - **HIGH** chance of dozing

Sitting reading a book.	☐ 0	☐ 1	☐ 2	☐ 3
Watching television.	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place. e.g. in a meeting	☐ 0	☐ 1	☐ 2	☐ 3
A passenger in a car for an hour without break	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon	☐ 0	☐ 1	☐ 2	☐ 3
Sitting talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, stopped in traffic or at lights	☐ 0	☐ 1	☐ 2	☐ 3

STOP-BANG Sleep Apnoea Questionnaire

For a Medicare subsidised sleep study, a patient must score 4 or more.
Each question is worth 1 point.

Total Score:

Please Select **YES** or **NO**

Do you **SNORE** loudly (Louder than talking or loud enough to be heard through closed doors)?	☐ Yes	☐ No
Do you often feel **TIRED**, fatigued or sleepy during day time?	☐ Yes	☐ No
Has anyone **OBSERVED** you stop breathing during your sleep?	☐ Yes	☐ No
Do you have or are you being treated for high blood **PRESSURE**?	☐ Yes	☐ No
BMI more than 35 kg/m2?	☐ Yes	☐ No
Age over 50 years old?	☐ Yes	☐ No
Neck Circumference > 16 inches (40cm)	☐ Yes	☐ No
Gender: Male?	☐ Yes	☐ No

Patient Height: ______________________ Patient Weight ______________________

SYMPTOMS (Please mark appropriate boxes)

☐ Snoring	☐ Witnessed apnoeas/nocturnal gasping/choking	☐ Daytime lethargy/sleepiness
☐ Weight gain	☐ Cognitive impairment	☐ Waking up with headache
☐ Insomnia	☐ Restless sleep	☐ Irritability

RELEVANT MEDICAL CONDITIONS (Please mark appropriate boxes)

☐ Hypertension	☐ Cardiac failure	☐ Stroke/TIA	☐ COPD	☐ Overweight
☐ Pacemaker	☐ Type II Diabetes	☐ Atrial Fibrillation	☐ Family history (OSA)	☐ Epilepsy
☐ Restless Legs	☐ Thyroid Disease	Other:		

Patient Signature ______________________ Date: ___ / ___ / ______