REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**SLEEP DISORDERS CLINIC**

Template for correspondence about patient with

**SLEEP DISORDERED BREATHING (ADULTS)**

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| **SEND TO** Dr Bajee Krishna Sriram (Clinical Director, Sleep Services)Outpatient Access and Scheduling CentreFax: 07 5687 4497  **OR****Secure transmission service via Medical Objects or****Healthlink to****QHEALTH,GOLD COAST HEALTH Outpatients****Outpatient Bookings and Referrals** | **FROM** **Doctors Name:** **Practice Name:****Practice Address:****Phone:** **Fax:** **Email:** **Provider Number:**  |

Dear Dr Sriram,

**SECTION 1 Patient details**

**Patient Full Name:**

**DOB:**

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| **Gender:** **Address:** **Home Ph:****Mobile Ph:** **Medicare Number\*:** (\*Medicare ineligible patients will incur a consultation fee) | **Next of Kin/Alternative Contact:** **Next of Kin/Alternative Contact Ph:** **Does patient identify as Aboriginal and/or Torres Strait** **Islander:****Interpreter required:** **If yes, specify language:**  |

**SECTION 2 Reason for referral and additional clinical information**

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| What is the reason for this referral: Please provide provisional diagnosis (if available): Please include any symptoms and date of onset (if known): **Paste or type relevant history, clinical examination findings and treatment to date if required** |

**SECTION 3 Mandatory clinical information**

Blood Pressure:

Neck circumference:

Sleep Apnoea device currently used:

Specify details of device if known:

**SECTION 4 Investigations**

Please indicate whether the following pre-requisite investigations have been undertaken in order for this referral to be processed and attach the results. In addition, please also attach any investigation results you consider to be relevant such as: assessments and findings from previous sleep studies and/or specialists in sleep medicine.

**Epworth Sleepiness Scale results**:

**Sleep study results**:

**The reasons why sleep study results are important are that applications for a QHSDP machine has to include the actual studies and some private sleep testing companies only release study results to the referring doctor not third parties.**

**SECTION 5 Duration of Referral**

Please indicate how long you would like your referral to remain valid:

[ ]  12 months

[ ]  Indefinite

Indefinite referrals do not expire until the patient has been discharged by the hospital service. When referrals expire, there is an expectation that the referring GP or another GP will review the care of the patient. If the patient still requires specialist care, the GP will then have to request a referral continuation.

**SECTION 6 Medical history including co-morbidities and previous surgical interventions**

Please consider whether the patient may have any of the following conditions that have not yet been coded into the electronic medical record; Cardiac arrhythmias; GORD; Heart failure; Diabetes mellitus; Motor neurone disease; COPD; Stroke/TIA; Chronic pain; Epilepsy/Seizures; Fibromyalgia.

**Alcohol Status/History:**

**Smoking Status/History:**

**Medical History:**

**Comorbidities:**

**Previous Procedures:**

**Allergies/Adverse Reactions:**

**Current prescribed medications:**

**SECTION 7 Information about this service**

**Information about the Queensland Health Sleep Disorders Program (QHSDP)**

Please provide concession card holders who are eligible for the Queensland Health Sleep Disorders Program (QHSDP) with information about the QHSDP equipment eligibility criteria:

1. They must reside permanently in Queensland.

2. They must be diagnosed with significant sleep apnoea as defined by the QH Sleep Disorders Program:

* + At least moderate sleep apnoea, e.g. Apnoea Hypopnea Index (AHI) of >15/hour on a diagnostic sleep study;
	+ Obstructive sleep apnoea of any severity if it is associated with excessive daytime sleepiness, as defined by an Epworth Sleepiness Scale (ESS) of >10/24 and other causes for the symptoms have been excluded;
	+ Patients with mild sleep apnoea (AHI <15/hr) without significant daytime sleepiness, e.g. Epworth Sleepiness, Scale (ESS ,10/24 will require approval from the Sleep Disorders Program Executive Committee for issue of equipment;

3. Patients have to rent a positive airway pressure device at their own expense for a minimum of two (2) month period of home treatment, with average usage of at least 4 hours per night for this period.

4. Patients have to purchase all accessories for the device, including mask, headgear, and if (required) humidifier, including after the two month trial period.

**SMOs/VMOs in this Specialist Service**

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| Dr Bajee Krishna Sriram (Clinical Director) | Dr Carl Pahoff | Dr Toby Tang |