Home Sleep Study Referral Form

Referring Doctor

Initials and Surname : _____

Contact Number : _____

Practice Number : _____

Signature : _____

Date : _____

Patient Details

Name and Surname : _____

Address : _____

_____

_____

Landline Number : _____

Cell Number : _____

Service Requested

☐ **Overnight ambulatory investigation for Sleep Apnea and clinical review**

Please tick eligibility criteria below. Criteria set by sleep Specialist to ensure test is necessary

Reason for referral – please tick 2 or more

☐ **Witnessed apneas or choking**

☐ **Regular loud snoring**

☐ **Regular fatigue or sleepiness**

☐ **CV risk factors** (Hypertension, Diabetes, BMI > 30 or other heart disease)

Other history _____

Medical Aid Details

Medical Aid

Medical Aid Number Dependent No

Plan / Option Date of Birth

Terms and conditions: Please refer to the terms and conditions on page 2.

I _____ (Name and Surname of patient) hereby give VitalAire (Pty) Ltd permission to submit my details to the medical aid and apply for authorisation, if required.

Signature: _____

Terms and Conditions

1. Sleep Study

1.1 I understand that my Physician has referred me to VitalAire to undergo a sleep study and I agree to undergo this study.

1.2 The testing equipment for this study will be hired out by VitalAire to me.

1.3 I agree that the data collected during the sleep study will be send to the Clinical Technologist for interpretation of raw data and recommendation.

1.4 The sleep study report will be forwarded to my referring Physician or Specialist.

1.5 I acknowledge that my Physician will inform me of the results of the sleep study and recommend further treatment if required.

2 CPAP Titration test

2.1 In an event that sleep apnea is diagnosed pursuant to the sleep study, I agree to undergo a CPAP titration test (being the process to determine the correct pressure setting for the CPAP machine) if this been requested by my referring Physician.

2.2 The testing equipment for the CPAP titration test will be hired out by VitalAire to me.

2.3 I agree that the data collected during the CPAP titration test will be send to the Clinical Technologist for interpretation of raw data and recommendation.

2.4 The sleep study report will be forwarded to my referring Physician or Specialist.

2.5 I acknowledge that my Physician will inform me of the results of the sleep study and recommend further treatment if required.

3. CPAP Treatment

3.1 if treatment with CPAP (meaning Continuous Positive Airway Pressure) is prescribed by my referring Physician or Specialist, I acknowledge that I can obtain a CPAP machine from VitalAire by either purchasing the CPAP machine from VitalAire (in which event payment for the CPAP machine will be made either by myself or by my medical aid, as the case may be) or enetering into a written equipment rental agreement with VitalAire.

4. Medical Authorisation

4.1 I hereby give VitalAire permission to contact my medical aid and to apply for authorisation in respect of the hiring of the testing equipment for the sleep study and the CPAP titration test (if applicable) (hereinafter referred to as the "fee for service") and the rental or purchase (as the case may be) of the CPAP machine (if applicable), if the medical aid details have been provided by me on this form.

4.2 4.2 I understand that payment remains my responsibility and that of authorisation has been obtained from my medical aid, my medical aid do not pay in full or at all and I will in such event be responsible for the payment of any shortfall.

4.3 Alternatively, if my medical aid makes any payment directly to me, I am responsible to pay VitalAire directly for services rendered by VitalAire immediately on receipt of payment from the Medical Aid.

5. Scheduling of appointments

5.1 VitalAire will contact me to schedule an appointment for the sleep study, CPAP titration test (if applicable) and delivery of the CPAP machine (if applicable) and the time when the technician / VitalAire Nurse will arrive at ..... or other location specified by me. I will ensure that I am at my residence or other location specified by me at the scheduled time of arrival of the technician or VitalAire Nurse. Changing of location must be arranged with VitalAire 48 hours prior to the scheduled appointment.

6. Confidentiality

6.1 All information obtained during the sleep study, CPAP titration test (if applicable) and CPAP compliance data (if applicable) will be handed by VitalAire in strict confidence and will only be sent to my referring Physician, the Physician named by my referring Physician in the referral form, the specialist shosen by VitalAire within its network of Physicians (if no Physician is named by my referring Physician in the referral form), to my medical aid if authorization is required, to myself or alternatively to such a person I appoint in writing and consent to.

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