



**Dr Robyn O'Sullivan FRACP**  
Provider No 0123054H

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Provider No 957565K

## SLEEP STUDY REFERRAL FORM

### PATIENT DETAILS/HOSPITAL ID STICKER

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_

Date of birth \_\_\_\_\_

**COMMERCIAL DRIVER**  Yes  No      **SPECIALIST CONSULT**  Yes  No

**STUDY TYPE REQUEST**  Diagnostic  CPAP titration  CPAP check

MAS  TcCO<sub>2</sub>  Waking ABGs  Supplemental O<sub>2</sub> \_\_\_\_\_

Home sleep study - 15 channel (Bulk-billed)

**By Sleep Specialist referral only:**  NIV  ASV  MSLT  MWT  10-20 EEG

### INDICATIONS FOR STUDY

**SYMPTOMS**  Snoring  Wakes choking  Witnessed apnoeas  Nocturia

Restless legs  Drowsy driving  Memory problems  Morning headache

**CO-MORBIDITIES**  Hypertension  Ischaemic heart disease  Diabetes

Atrial fibrillation  CVA  Epilepsy  Depression

### MEDICATION LIST/ OTHER MEDICAL PROBLEMS

- attach list if insufficient space

**REFERRING DOCTOR** Name \_\_\_\_\_

Address \_\_\_\_\_

Provider No. \_\_\_\_\_ Signature \_\_\_\_\_

Copy to: \_\_\_\_\_ Date \_\_\_\_\_

**SLEEP CARE - [www.sleepcare.com.au](http://www.sleepcare.com.au)**

Tel: 1300 75 33 75 / 07 3397 3036 Fax: 07 3397 3013

Email: [admin@sleepcare.com.au](mailto:admin@sleepcare.com.au)

Greenslopes Private Hospital  Sunnybank Private Hospital  St Andrews Sleep Centre

Newdegate St

245 McCullough St

33 North St

Greenslopes Q 4120

Sunnybank Q 4109

Spring Hill Q 4000

Bulk-billed (uninsured patients)