Dr Robyn O'Sullivan FRACP
Provider No 0123054H

Dr Allan Finnimore FRACP
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 ❏ TcCO2 ❏ Waking ABGs ❏ Supplemental O2 _________

❏ 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 ❏ Restless legs ❏ Drowsy driving ❏ Memory problems

❏ Morning headache ❏ Nocturia

CO-MORBIDITIES

❏ Hypertension ❏ Ischaemic heart disease ❏ Atrial fibrillation ❏ Diabetes ❏ CVA ❏ Epilepsy ❏ Depression

MEDICATION LIST - attach list if insufficient space

OTHER MEDICAL PROBLEMS

REFERRING DOCTOR DETAILS

Name ____ Provider No. ______________________

Address ____ Postcode _____________

Signature __________________________________ Date ______________________

Copy to ____

SLEEP CARE - www.sleepcare.com.au - 1300 75 33 75

Tel: 07 3397 3036 Fax: 07 3397 3013 Email: admin@sleepcare.com.au

❏ Greenslopes Private Hospital
Newdegate St, Greenslopes Q 4120

❏ Sunnybank Private Hospital
245 McCullough St, Sunnybank Q 4109

❏ St Andrews Sleep Centre
33 North St, Spring Hill Q 4000
Bulk-billed (uninsured patients)