Sleep Study Date

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Referral

☐ Dr Dimitar Sajkov ☐ Dr Jeffrey Bowden ☐ Dr Sharon Morton ☐ Dr Jason D'Costa
☐ Dr Anand Rose ☐ Dr Vinod Aiyappan ☐ Dr Mohd Shah Mohd Shif ☐ Dr Sudhir Rao
☐ Dr Karen Latimer ☐ Dr Peter Allcroft ☐ Dr Madhu Chandratilleke ☐ Sleep Registrar
☐ Refer to Dr Sajkov if no preference (*next available appointment with any specialist*)

TEST REQUESTED:

☐ Diagnostic Polysomnography (PSG) ☐ Sleep Specialist Consultation
☐ CPAP titration study ☐ Multiple sleep latency test (MSLT)
☐ Bi-PAP / ASV non-invasive ventilation trial ☐ Other: ______________________

PATIENT DETAILS

Patient Name: ______________________ Sex (circle): M / F
Address: ______________________
______________ DOB: ______________ Fund Name: ______________
Tel: ______________ Mobile: ______________ Fund Number: ______________
Medicare No: ______________________ M/C Exp date: ______________

☐ Private Patient ☐ DVA Gold Card Holder ☐ Medicare only

Clinical Details:

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Study Date: ______________________ Follow-up Date: ______________

EXTRA MEASUREMENTS OR OBSERVATIONS (eg T_CCo_2, video monitoring) Yes / No
SPECIAL ASSISTANCE (e.g. transferring to bed, turning during the night) Yes / No
Does the patient suffer from any communicable or infectious disease? Yes / No

If yes to either of the above please specify:______________________

Referring Doctor
Doctor's Name: ______________________ Provider No: ______________________
Address: ______________________
Tel: ______________________ Fax: ______________________
Signature: ______________________ Date: ______________________
Specialist approval of the test prior to consultation
Specialist Signature: ______________________ Date: ______________________