RESPIRATORY & SLEEP MEDICINE
PRACTICE
ABN: 26 600 602 284

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Patient Details

Name: ____ Date of Birth: _____________________

Address: ____ Medicare: ________________________

Purpose of consultation: *(Please indicate)*

- ❑ Sleep Investigation
- ❑ Chest Infection
- ❑ Investigation of abnormal radiology
- ❑ Other: ____
- ❑ Asthma
- ❑ Assessment of breathlessness
- ❑ Cough
- ❑ COPD

Respiratory Function Tests: *(Please indicate)*

- ❑ Spirometry
- ❑ Comprehensive Lung Function Test
- ❑ Nasal Resistance

Sleep Test: *(Please indicate)*

- ❑ In-lab Diagnostic Sleep Study
- ❑ Bi-level Treatment Study
- ❑ Home Diagnostic Sleep Study
- ❑ CPAP Treatment Study

With:

- ❑ TcCO2 Monitoring
- ❑ Oxygen Titration
- ❑ Overnight Oximetry Monitoring

Additional Services Available:

- ❑ MAS
- ❑ Anapnoea Clinic (CPAP/BiPAP Clinic)
- ❑ MSLT
- ❑ Consultation with Sleep Physiologist
- ❑ MWT
- ❑ CPAP/BiPAP Hire

Patient Presentation: *(Please indicate)*

- ❑ Congestive Heart Failure
- ❑ Excessive Daytime Sleepiness
- ❑ Abnormal Activity During Sleep
- ❑ Witnessed Apnoeas
- ❑ Snoring
- ❑ Insomnia
- ❑ Narcolepsy
- ❑ Restless Legs
- ❑ Hypertension
- ❑ Diabetes Type 2
- ❑ BMI >30
- ❑ Mobility Impairment
- ❑ Arrhythmia
- ❑ Nocturia
- ❑ Commercial Driver

Clinical History: ____
____
____

Practice Stamp:

Doctor: ____________________________
Date: ______________________________

Patients will be contacted by our friendly staff with arrangements.
Thank you for your referral.

the SLEEP LABORATORY