Sleep Study Request Form

PLEASE INDICATE YOUR PREFERRED CONSULTANT:

- ☐ Dr. Peter Robinson
- ☐ Dr. Hugh Greville
- ☐ A/Prof. Mark Holmes
- ☐ A/Prof. Raffaele Scicchitano
- ☐ A/Prof. Hubertus Jersmann
- ☐ A/Prof. Paul Reynolds
- ☐ Dr. Dimitar Sajkov

In association with: The **Burnside Sleep Centre, Burnside War Memorial Hospital** Inc.

Ph: (08) 8202 7272 Fax: (08) 8331 7152 Email: sleep-lung@burnsidehosptial.asn.au

PATIENT DETAILS

Mr/Mrs/Ms/Other:..................... Surname:..

Given Name(s):... D.O.B:.....................................

Address:...

.... Post Code:......................... Tel: H).......................................

W).. Mob)...................................... Medicare #:.............................

Health Fund:... Fund #:...

CLINICAL DETAILS

Please indicate reasons for referral:..

....

Other relevant medical conditions:...

....

REFERRING DOCTOR'S DETAILS

Name: ....

Address: ....

....

Telephone:...

ADDITIONAL SLEEP STUDY REPORTS TO:

Name: ....

Address: ....

Name: ....

Address: ....

Doctor's Signature: .... Date: ..../......./........

REPORTING SPECIALIST ONLY

Test required *(please tick)*: ☐ Diagnostic ☐ CPAP Titration ☐ Other.................................

Study Date:.............../.............../................... Follow-up Date:.............../.............../...................

Signature:.. Date: ..../......./........

Please forward request form to: The Burnside Sleep Centre, 120 Kensington Road, Toorak Gardens SA 5065