



Burnside Sleep Centre

Sleep Study Request Form

PLEASE INDICATE YOUR PREFERRED CONSULTANT:

- | | |
|--|--|
| <input type="checkbox"/> Dr. Peter Robinson | <input type="checkbox"/> Dr. Hugh Greville |
| <input type="checkbox"/> A/Prof. Mark Holmes | <input type="checkbox"/> A/Prof. Paul Reynolds |
| <input type="checkbox"/> A/Prof. Hubertus Jersmann | <input type="checkbox"/> Dr. Dimitar Sajkov |
| <input type="checkbox"/> Dr. Chien-Li Liew | |



PATIENT DETAILS

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

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

Address:.....

..... Post Code:..... Medicare No:.....

Tel: H)..... W)..... Mob).....

Health Fund:..... Fund No:.....

CLINICAL DETAILS

Please indicate reasons for referral:.....

.....

Other relevant medical conditions:.....

.....

REFERRING DOCTOR'S DETAILS

Name:

Address:

..... Name:

Telephone:..... Address:

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

ADDITIONAL SLEEP STUDY REPORTS TO:

Name:

Address:

Name:

Address:

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

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