Burnside Sleep Centre

Sleep Study Request Form

PLEASE INDICATE YOUR PREFERRED CONSULTANT:

- ☐ Dr. Peter Robinson
- ☐ Prof. Mark Holmes
- ☐ A/Prof. Hubertus Jersmann
- ☐ Dr. Jonathon Polasek
- ☐ Dr. Hugh Greville
- ☐ Prof. Paul Reynolds
- ☐ Dr. Chien-Li Holmes-Liew
- ☐ Dr. Sutapa Mukherjee
- ☐ Dr. Dien Dang
- ☐ Dr. Aeneas Yeo
- ☐ Dr. Dimitar Sajkov

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: .....

.....

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

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

ONLY FIVE [5] PAGES REMAINING IN THIS PAD

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