



# Burnside Sleep Centre

## Sleep Study Request Form

### PLEASE INDICATE YOUR PREFERRED CONSULTANT:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Prof. Mark Holmes       | <input type="checkbox"/> A/Prof. Chien-Li Holmes-Liew | <input type="checkbox"/> Dr. Dien Dang          |
| <input type="checkbox"/> Prof. Hubertus Jersmann | <input type="checkbox"/> Dr. Aeneas Yeo               | <input type="checkbox"/> Dr. Zafar Usmani       |
| <input type="checkbox"/> Prof. Paul Reynolds     | <input type="checkbox"/> A/Prof. Sutapa Mukherjee     | <input type="checkbox"/> Dr. Simone Barry       |
| <input type="checkbox"/> Dr. Jonathon Polasek    | <input type="checkbox"/> Dr. Sanaz Lehman             | <input type="checkbox"/> Dr. Shanka Karunaratne |

### 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:.....

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

### ADDITIONAL SLEEP STUDY REPORTS TO:

Name: .....

Address: .....

.....

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: sleepadmin@burnsidehospital.asn.au

