Burnside Sleep Centre

Sleep Study Request Form

PLEASE INDICATE YOUR PREFERRED CONSULTANT:

- ☐ Dr. Hugh Greville
- ☐ Prof. Mark Holmes
- ☐ A/Prof. Hubertus Jersmann
- ☐ Prof. Paul Reynolds
- ☐ Dr. Jonathon Polasek
- ☐ Dr. Chien-Li Holmes-Liew
- ☐ Dr. Aeneas Yeo
- ☐ Dr. Sutapa Mukherjee
- ☐ Dr. Sanaz Lehman
- ☐ Dr. Dimitar Sajkov
- ☐ Dr. Dien Dang
- ☐ Dr. Shanka Karunarathne
- ☐ Dr. Zafar Usmani

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: ……

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

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