NT MEDICAL SPECIALIST

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REFERRAL FOR CONSULTATION / SLEEP STUDIES

Patient details	Surname		DOB		
	Given name		Gender	☐ M	☐ F
	Address		Tel (H)		
			Tel (M)		
			Tel (W)		
Referring doctor	Name				
	Provider no				
	Address				
	Tel	Fax	Email		
Clinical	☐ Snoring		☐ Excessive daytime sleepiness		
	☐ Apnoea		☐ Insomnia		
	☐ Unrefreshing sleep		☐ Restless legs		
	☐ Poor concentration/memory		☐ Occupational		
	Others (Please specify)				
Request	☐ Consultation prior to study		☐ Dental device review study		
	☐ Diagnostic sleep study		☐ MSLT		
	☐ CPAP implementation study		☐ MWT		
	☐ CPAP treatment review study				
	Others (Please specify)				
Priority	☐ Urgent	☐ Semi-urgent	☐ Non-urgent		
Date of request		Signature of requesting doctor			