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HOME SLEEP MONITORING

Sleep Investigation Referral

Patient Details

Family Name: _____ Given Names: _____ M / F

DOB: ____ / ____ / ____ Height: _____ cm Weight: _____ kg Neck Circumference: _____ cm

Address: _____

Suburb: _____ Postcode: _____

Home: _____ Work: _____ Mobile: _____

Medicare Number: _____ Reference Number: _____

Reason For Referral

- ☐ Home Sleep Study with Sleep Physician Review
- ☐ Sleep Physician Consultation

Type of Study

- ☐ Diagnostic
- ☐ With APAP
- ☐ With CPAP
- ☐ MAS Review

Clinical Notes

_____

_____

_____

_____

_____

Indications

☐ Snoring	☐ Nocturia	☐ Poor Concentration	☐ Poor Libido
☐ Nocturnal Choking	☐ Night Sweats	☐ Memory Loss	☐ Drowsy Driving
☐ Witnessed Apnoeas	☐ Disturbed Sleep	☐ Mood Swings	☐ Mouth Dryness
☐ Coughing	☐ Leg Movements	☐ Excessive Sleepiness	☐ Pre Surgery
☐ Nasal Congestion	☐ Morning Headaches	☐ Poor Sleep Hygiene	☐ Bruxism
☐ Breathlessness	☐ Unrefreshed in AM	☐ Insomnia	☐ TMJ Pain

Medical Conditions

☐ IHD	☐ Pacemaker	☐ Neuromuscular Disease	☐ Obesity
☐ CCF	☐ Asthma	☐ GO Reflux	☐ Depression
☐ Hypertension	☐ COAD	☐ Diabetes	☐ Epilepsy

Referring Practitioner Details

Name: _____ GP/ Specialist: (type) _____

Clinic: _____ Telephone: _____

Address: _____

Suburb: _____ Postcode: _____

Signed: _____ ____ / ____ / ____ Provider No. _____