Sleep Study Date

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Referral

☐ Refer to A/Prof Dr Sajkov if no preference (*next available appointment with any specialist*)

☐ Dr Dimitar Sajkov ☐ Dr Sarah Newhouse ☐ Dr Mohd Shah Mohd Shif ☐ Dr Sudhir Rao ☐ Dr Anuk Kruavit ☐ Dr Jien Ni Cheng ☐ Dr Carissa Yap

TEST REQUESTED:

☐ Diagnostic Polysomnography (PSG)
☐ CPAP titration study
☐ Bi-PAP / ASV non-invasive ventilation trial
☐ Sleep Specialist Consultation
☐ Multiple sleep latency test (MSLT)
☐ Other: _____

PATIENT DETAILS

Patient Name: _____ Sex (circle): M / F

Address: _____

DOB: _____ e-mail: _____ Fund Name: _____

Tel: _____ Mobile: _____ Fund Number: _____

Medicare No: _____ M/C Exp date: _____

☐ Private Patient ☐ DVA Gold Card Holder ☐ Medicare only

Clinical Details (see over): **ESS = …. /24** **OSA50 = …. /8**

_____

_____

_____

Study Date: _____ Follow-up Date: _____

EXTRA MEASUREMENTS OR OBSERVATIONS (eg T_CCo_2, video monitoring) Yes / No
SPECIAL ASSISTANCE (e.g. transferring to bed, turning during the night) Yes / No
Does the patient suffer from any communicable or infectious disease? Yes / No

If yes to either of the above please specify:_____

Referring Doctor

Doctor's Name: _____ Provider No: _____

Address: _____

Tel: _____ Fax: _____

Signature: _____ Date: _____

Specialist approval of the test prior to consultation (if ESS ≥ 8/24 and OSA50 ≥ 4/8)

Specialist Signature: _____ Date: _____