

Referral Form

Please send your referral to:

Fax: 1300 360 239 or Email: info@ressleep.com.au

Our staff will contact the patient to book an appointment. Patients: Please bring this referral to your appointment.

Patient Name _____ Phone _____

Email _____ Commercial drivers licence Yes No

Symptoms (please tick appropriate box/es)

- Snoring Witnessed apneas / nocturnal gasping / choking Daytime lethargy / sleepiness

Relevant Medical Conditions (please tick appropriate box/es)

- Hypertension Cardiac Failure Stroke/TIA COPD
 Type II Diabetes Atrial Fibrillation Obesity Other _____
 Clinical History (optional, attach notes to this referral)

Request for (please tick appropriate box/es)

- Home sleep test for suspected Sleep Apnea**
(In accordance with Medicare item 12250, all sleep assessments and appropriateness of home tests are overseen by the supervising Sleep Physician. Based on these assessments and the study findings, certain complex patients may require a Sleep Physician consultation).
- CPAP / APAP Treatment Trial** - for the treatment of Sleep Apnea
- Mandibular Advancement Oral Device (fitted by a Dentist) - for the treatment of Snoring only
- Mandibular Advancement Oral Device (fitted by a Dentist) - for the treatment of Snoring and mild to moderate Sleep Apnea
- VPAP Adapt Treatment Trial - for the treatment of suspected Complex Sleep Apnea and / or Central Sleep Apnea.
- VPAP S / ST / ST-A Treatment Trial - for the treatment of suspected COPD or for pressure assisted therapy
- Pressure / Treatment review with oximetry

FOR THIS REFERRAL TO BE VALID, PLEASE ENSURE THAT THE FOLLOWING DETAILS ARE COMPLETED:

Referring Doctor: _____ Doctor's Signature: _____

Provider Number: _____ Date of referral: _____

Practice Name: _____ Phone: _____

Address: _____

Email: _____ Fax: _____

Please indicate how you would like to receive results and other correspondence from ResSleep:

- Electronic transfer of reports via secure messaging Email Fax Post

If you answer 'Yes' to three or more of these questions you are at high risk of having sleep apnea.

Adapted from P.F.Grunstein et al. The Norwich Questionnaire. Presented at the American Thoracic Society Meeting 2008

Y

Your BMI is >25?

A

Are you aware that you have been snoring or have pauses in your breathing when you sleep?

W

Waking unrefreshed most mornings?

N

Nodding off easily during the day?

Clinic Locations

New South Wales

Bella Vista

1 Elizabeth Macarthur Drive
Bella Vista 2153

Bondi Junction

Suite 1104, Level 11
1 Newland Street
Bondi Junction 2022

Dee Why

850 Pittwater Road
Dee Why 2099

Gosford

Suite B, 201 Mann Street
Gosford 2250

Hornsby

Suite 2, Rear Ground Floor
149 Pacific Highway
Hornsby 2077

Miranda

Suite 201, 29 Kiara Road
Miranda 2228

Newcastle

356 Hunter Street
Newcastle 2300

North Ryde

Suite 8, 33 Waterloo Road
North Ryde 2113

Sydney CBD

Mezzanine Level, Kyle House
27-31 Macquarie Place
Sydney 2000

Queensland

Chermside

960 Gympie Road
Chermside 4032

Mt Gravatt

1389 Logan Road
Mt Gravatt 4122

Greenslopes

15 Montague Street
Greenslopes 4120

South Australia

Brighton

425 Brighton Road
Brighton 5048

North Adelaide

120 Childers Street
North Adelaide 5006

Victoria

Kew

154 High Street
Kew 3101

Mt Waverley

Suite 2, 1 Hardner Road
Mount Waverley 3149

Western Australia

Perth CBD

Suite 27, Mount Medical Centre
146 Mounts Bay Road
Perth 6000

Joondalup

Suite 13, Shenton House
57 Shenton Avenue
Joondalup 6027

1300 wakeup
1300 925 387