Fax Referral Form to:

national Sleep Diagnostics
Sleep well, breathe easy.
PO Box 115 Oakleigh, VIC 3166
Ph: 1300 852 997 Fax: 1300 852 998
Email: info@sleepdiagnostics.com.au

Sleep Test Referral

Ambulatory Home Sleep Test

Patient Information

Surname		D.O.B.		☐ Male ☐ Female	
Given Names					
Address				Postcode	
				Phone	
Medicare No				Private health insurance ☐ Yes ☐ No	

Indications, Symptoms and Health Comorbidities

Please check two or more eligibility criteria

Eligibility criteria are set by Accredited Sleep Physician to ensure test is necessary and will be undertaken. This communicates the need for testing to the referring medical practitioner.

- ☐ Disruptive snoring
- ☐ Apnoea, choking or gasping
- ☐ Insomnia or awakenings
- ☐ Bruxism
- ☐ Nightmares or morning headaches
- ☐ Nocturia – excessive
- ☐ Periodic leg movements (PLMS, RLS)
- ☐ Other: *Please specify* _____
- ☐ Daytime sleepiness or excessive fatigue
- ☐ Broken, restless or unrefreshing sleep
- ☐ Obesity
- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart disease or CCF
- ☐ Arrhythmia or palpitations
- ☐ Sleepy or drowsy driving

Telehealth Consultation ☐ Yes ☐ No

Referring Doctor

Date		Provider No.	
Name			
Address			
		Postcode	
Phone		Fax	
Email		Signature	

***Report Preference*:** Mail ☐ Fax ☐ Email ☐ HealthLink ☐