1800MYSLEEP Sleep Disorder
Diagnosis Treatment Support
FAX 03 7048 3131 ••• 1800 697 533
admin@1800mysleep.com.au
Healthlink: Sleeppap Argus: Sleeppap_coreplus@argus.net.au

Service Referral

Patient Given Name (as per Medicare card) *

Patient Surname (as per Medicare Card) *

DOB *

Phone *

Address

Medicare

Ref

Exp

Referral to Our Service Includes Referral to Sleep and Respiratory Physiologists, Cardiopulmonary Physiotherapists and Specialist Sleep and Respiratory Physicians for Opinion, Treatment and Review; as well as Clinically Relevant Assessments Such as Home Based Sleep Studies and Lung Function Testing. Please Select the Services You Would Like Offered to Your Patient Initially: *

- [ ] Home Sleep Study - Streamlined Access with Physiologist Review for Results.
- [ ] Home Sleep Study with Sleep Physician Telehealth Review for Results.
- [ ] Streamlined Level 1 Attended Sleep Study and Sleep Physician Telehealth Assessment.
- [ ] Complex Lung Function Testing.

Sleep Questionnaire signs (Our intake assessment covers this is detail)

- [ ] Excessive Daytime Sleepiness
- [ ] - Epworth Sleepiness Scale above 8
- [ ] Snoring
- [ ] - Loud and/or Frequent
- [ ] Tiredness
- [ ] - Frequent and/or Nodded off Whilst Driving
- [ ] Witnessed Apnea
- [ ] High Blood Pressure
- [ ] Obesity (BMI > 30)
- [ ] Age (over 50)
- [ ] Large Neck
- [ ] Male
- [ ] GORD or Nocturnal Reflux

Other Clinically Relevant Symptoms and Comorbidities

- [ ] Diabetes
- [ ] Insomnia
- [ ] Unrefreshing Sleep
- [ ] Migraines
- [ ] Morning Headaches
- [ ] Depression / Anxiety
- [ ] Shortness of Breath
- [ ] Cardiovascular Disease
- [ ] History of Stroke or Heart Attack
- [ ] History or Suspicion of Asthma
- [ ] History or Suspicion of Allergies
- [ ] History or Suspicion of an Autoimmune Condition
- [ ] History or Suspicion of a Neuromuscular Disease
- [ ] Chest Deformity or Suspected Respiratory Muscle Weakness

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Additional Information, Relevant History and Medications:

Referring Doctor Name *

Provider Number *

Physician Phone *

Physician Fax

Referring Doctor Address *

Street address *

City *

State *

Please select

Postcode *

Date of Referral *

Request Urgency

- Category 1 (Very Urgent- within 30 days)
- Category 2 (Urgent- within 3 months)
- Category 3 (Standard- within 12 months)

Duration of Referral

- 3 months (Specialist)
- 12 Months (GP)
- Indefinite

Location

- Morwell
- Geelong
- Visiting Regional Clinic

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Any other notes for the Medical Scientist or Doctor

Submit