Chemmart Health Services
SleepApnoea Program

national SleepDiagnostics
PO Box 115, Oakleigh VIC 3166
Ph: 03 9503 8356
Fax: 03 9503 9399
info@sleepdiagnostics.com.au
Sleep well. Breathe easy.

HOME SLEEP TEST REFERRAL FORM

Patient Details

Patient Name ______________________

Patient Address ______________________ Ph: ______________

Medicare No. ______________________ DOB: ______________

Private Health Insurance ______________________ Male ☐ Female ☐

Clinical History

CO MORBIDITIES

- ☐ Hypertension
- ☐ Cardiac Stent or Angioplasty
- ☐ Erectile Dysfunction
- ☐ Dyslipidaemia
- ☐ Heart Attack - Infarct
- ☐ Respiratory Disease
- ☐ Obesity
- ☐ Cardiovascular Disease
- ☐ Atrial Fibrillation
- ☐ Stroke or TIA
- ☐ Arrhythmia
- ☐ Depression
- ☐ Diabetes
- ☐ Angina
- ☐ Nocturia

SYMPTOMS

- ☐ Snoring
- ☐ Restless or Broken Sleep
- ☐ Unrefreshed in am
- ☐ Insomnia
- ☐ Night Breathing Disturbance
- ☐ Frequent Awakenings
- ☐ Daytime Sleepiness/Fatigue
- ☐ Drowsy or Sleepy Driving
- ☐ Witnessed Breath holding
- ☐ Morning Dry/Sore Throat
- ☐ Poor Memory/Concentration
- ☐ Choking/Gasping
- ☐ Morning Headaches
- ☐ Irritability
- ☐ Other :

EPWORTH SLEEPINESS SCALE: ___ / 24

PATIENT NOTES : ______________________

Referring Doctor:

Name: ______________________

Address: ______________________

Email: ______________________ **Fax:** ______________

Provider Number: ______________________ **Ph:** ______________

Signature: ______________________

Upon receipt of this referral

1. Your patient will be contacted for overnight testing by Rachel Mulley's Chemmart
2. Sleep Consultant report will be forwarded to you upon completion
3. One of the following will be recommended by the Sleep Physician
   1.Consultation 2.Trial of CPAP treatment 3.Further investigation

THIS SIGNED FORM MUST BE FAXED TO RACHEL MULLEY'S CHEMMART FOR AN APPOINMENT TO BE MADE – FAX NO. IS 02 4987 2492