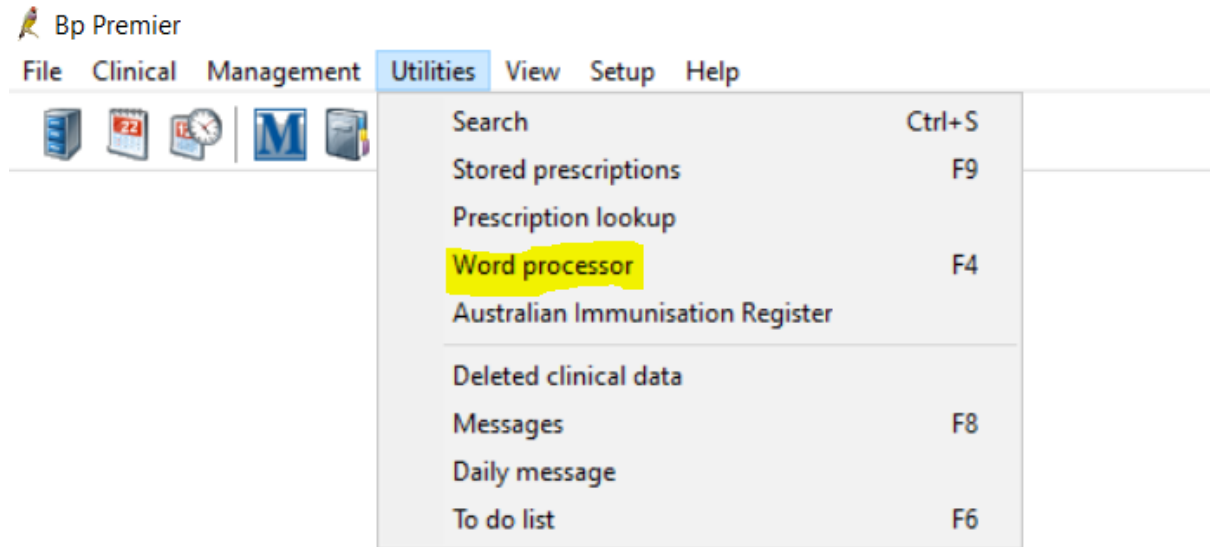


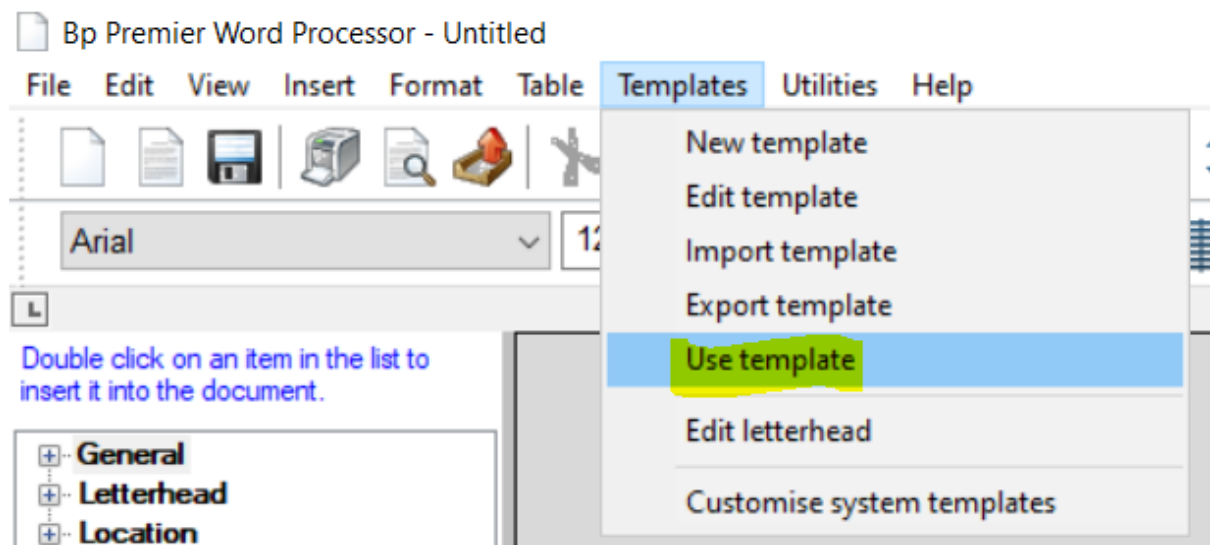
How to open and run your template in Best Practice.

Step 1. Open Best Practice

Step 2. Click Utilities > Word Processor



Step 3. Templates > Use Template



Step 4. Select the Template and click Open

Word Processor templates ✕

All
 Custom
 Supplied
 Include all states

Template name	All users	Type
Sleep study referral - Pacific Sleep	Yes	Custom
Sleep Study Referral (Cleveland)	Yes	Supplied
Sleep Study Referral NEW - Healthy Sleep & Snore	Yes	Supplied
Sleep study test referral BOC	Yes	Supplied
Sleep Testing Australia Referral Form	Yes	Supplied
Sleep Testing Australia Referral Form	Yes	Supplied
Sleep-About Sleep Ethical Sleep Studies No Gap	Yes	Supplied
Sleepmed Referral	Yes	Supplied
Snore Sleep Referral	Yes	Supplied
SomnoCare - Medical Sleep Services	Yes	Supplied
South West Radiation Oncology Referral	No	Custom
Specialist referral	Yes	Supplied
Sports & Spinal referral	Yes	Supplied
STAR Injury Management Services Referral Form	Yes	Supplied
SUFWB Referral Form	Yes	Supplied
Symbicort Action Plan	Yes	Supplied
TAC WorkSafe Certificate Of Capacity	Yes	Supplied
TAC WorkSafe Certificate Of Capacity	Yes	Supplied
TAC WorkSafe Certificate Of Capacity	Yes	Supplied
Tas - Worker'S Compensation 1	Yes	Supplied
Tas - Worker'S Compensation 2	Yes	Supplied
Telethon Speech and Hearing Referral Form-Adult	Yes	Supplied
Telethon Speech and Hearing Referral Paediatric	Yes	Supplied

Referral Form

NOTE FOR REFERRING DOCTORS: Patients under 18 years of age should be referred to a paediatric sleep physician.

Reporting physician
 Dr Michael Hayes FRACP
 Dr Chris Chapman FRACP
 A/Prof Stephen Celia FRACP
 Dr Alexander Fildes FRACP

Pacific Sleep
 Gosford Central Coast
 Erindale Newcastle
 Blacktown Sydney
 Hornsby
 Tel: 02 4338 1222
 Fax: 02 4338 1817

Please fax your referral to 02 4338 1817 or email referrals@pacificsleep.com.au.

Patients: Please complete referral to your appointment.

Patient name: *Full Name* Date of Birth: *DDMMYY*
 Address: *Address*
 Telephone: *Home/Mob* Email: *Email*
 Commercial driver licence: *Commercial driver licence*

SYMPTOMS AND MEDICAL CONDITIONS

Hypertension Hypertension	*Snoring* Snoring	*Apical Ectatic* Apical Ectatic
Cardiac *Atrial* Cardiac	*Overweight* Overweight	*Daytime* *Excessive* Daytime Excessive
Stroke / TIA Stroke / TIA	*Pacemaker* Pacemaker	*Family* *History* (OSA) Family History (OSA)
COPD COPD	*Type II* Diabetes Type II Diabetes	*Clinical* *History* *Clinical* *History* (asthma, ADHD, ADD, etc.)
Symptoms and Medical Conditions Other: *Symptoms and Medical Conditions - Other*		

REQUEST FOR (please tick the appropriate box/boxes)


Home *Diagnostic* *Sleep* *Study* (includes consultation with the reporting physician) Home Diagnostic Sleep Study (includes consultation with the reporting physician)	*Multiple* *Wakefulness* *Test* (MWT) *Multiple* *Wakefulness* *Test* (MWT)
Implement *CPAP* *Treatment* (with study) as required	*Altered* *Sleep* *Study* *Altered* *Sleep* *Study* (with study)
Prescribe *Respiratory* *Therapy* (with study) as required	*Supply* *CPAP* *Approved* *Equipment* & *Services* Supply of CPAP approved equipment & services
Other: *Request for - Other*	

REFERRING DOCTOR

Referring Dr: name: *Dr Name*
 Practice name: *Local or Home* Telephone: *Dr Practice*
 Address: *Dr Address*

Step 5. Select the patient

Select patient ✕



Select a patient from the database

Search for:

Name	Age	Address	D.O.B.

Step 6. Fill out the form

Sleep study referral - Pacific Sleep


Commercial drivers licence	<input type="text"/>
SYMPTOMS AND MEDICAL CONDITIONS	SYMPTOMS AND MEDICAL CONDITIONS <input type="button" value="v"/>
Hypertension	<input type="checkbox"/>
Snoring	<input type="checkbox"/>
Atrial fibrillation	<input type="checkbox"/>
Cardiac failure	<input type="checkbox"/>
Overweight	<input type="checkbox"/>
Daytime somnolence	<input type="checkbox"/>
Stroke / TIA	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>
Family history (OSA)	<input type="checkbox"/>
COPD	<input type="checkbox"/>
Type II Diabetes	<input type="checkbox"/>
Clinical history	<input type="checkbox"/>
Symptoms and Medical Conditions Other	<input type="checkbox"/>
Symptoms and Medical Conditions - Other	<input type="text"/>
REQUEST FOR (please tick the appropriate box/boxes)	REQUEST FOR (please tick the appropriate box/boxes) <input type="button" value="v"/>

< Back

Next >

Cancel

Step 7. Template has been Generated

<h1 style="margin: 0;">Referral Form</h1> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>NOTE FOR REFERRING DOCTORS: Patients under 18 years of age should be referred to a paediatric sleep physician.</p> </div> <p>Reporting physicians Dr. Michael Hayes FRACP Dr. Chris Duggan FRACP A/Prof. Stephen Cala FRACP Dr. Alex Erdstein FRACP</p>	 <h2 style="margin: 0;">Pacific Sleep</h2> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Gosford</td> <td>Central West</td> </tr> <tr> <td>Toukley</td> <td>Newcastle</td> </tr> <tr> <td>Blacktown</td> <td>Gympie</td> </tr> <tr> <td>Hornsby</td> <td></td> </tr> </table> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Tel 02 4339 1222</p> <p>Fax 02 4339 1617</p> </div>	Gosford	Central West	Toukley	Newcastle	Blacktown	Gympie	Hornsby	
Gosford	Central West								
Toukley	Newcastle								
Blacktown	Gympie								
Hornsby									

Please fax your referral to **02 4339 1617** or email referrals@pacificsleep.com.au.
 Patients: Please bring this referral to your appointment.

Patient name: Mrs. Madeline Jane Abbott	Date of Birth: 14/02/1978
Address: 12 John St Albany Creek 4035	
Telephone: 09789751131	Email: madi.abbott@bpsoftware.com.au
Commercial drivers licence:	

SYMPTOMS AND MEDICAL CONDITIONS		
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Snoring	<input type="checkbox"/> Atrial fibrillation
<input type="checkbox"/> Cardiac failure	<input type="checkbox"/> Overweight	<input type="checkbox"/> Daytime somnolence
<input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Family history (OSA)
<input type="checkbox"/> COPD	<input type="checkbox"/> Type II Diabetes	<input type="checkbox"/> Clinical history <small>(optional, attach notes to this referral)</small>
<input type="checkbox"/> Other:		

REQUEST FOR (please tick the appropriate box/boxes)	
<input type="checkbox"/> Home diagnostic sleep study (includes consultation with the reporting physician)	
<input type="checkbox"/> Implement CPAP treatment (with oximetry as required)	<input type="checkbox"/> Multiple Wakefulness Test (MWT)
<input type="checkbox"/> Pressure review study (with oximetry)	<input type="checkbox"/> Attended sleep study
<input type="checkbox"/> Supply of oxygen concentrator	<input type="checkbox"/> Supply of DVA approved equipment & services