

Referral Form



Pacific Sleep

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

Gosford
Toukley
Blacktown

Central West
Newcastle
Hornsby

Reporting physicians

Dr. Chris Duggan FRACP
A/Prof. Stephen Cala FRACP
Dr. Alex Erdstein FRACP

Tel **02 4339 1222**
Fax **02 4339 1617**

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

Patient name: _____ Date of Birth: ____ / ____ / ____

Address: _____

Telephone: _____ Email: _____

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
<i>(optional, attach notes to this referral)</i> |
| <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"/> Maintenance of Wakefulness Test (MWT) |
| <input type="checkbox"/> Implement CPAP treatment (with oximetry as required) | <input type="checkbox"/> Attended sleep study |
| <input type="checkbox"/> Pressure review study (with oximetry) | <input type="checkbox"/> Supply of DVA approved equipment & services |
| <input type="checkbox"/> Supply of oxygen concentrator | |

Other:

REFERRING DOCTOR

Referring Dr. name _____

Practice name _____ Provider no. _____

Address _____

Email _____

Phone _____ Fax _____

Referring Dr. signature _____ Referral date _____

Pacific Sleep locations

Blacktown

Blacktown Town Centre
Suite 9, 30 Campbell Street
Blacktown NSW 2148

Cowra

110 Kendal Street
Cowra NSW 2794

Gosford

Jarrett Street Specialist Centre
Suite 2, 14-18 Jarrett Street
North Gosford NSW 2250

Gympie, Qld

Mobile service

Hornsby

Suite 6B, Level 2
26 Florence Street
Hornsby NSW 2077

Newcastle

663 Glebe Road
Adamstown NSW 2289

Parkes

Parkes General Practice
25 Church Street
Parkes NSW 2870

Toukley

Suite 2, 45 Canton Beach Road
Toukley NSW 2263

Approved DVA Supplier providing
CPAP equipment for eligible DVA clients.

Registered NDIS Provider

Referrals

Please send your referral to us by fax on
02 4339 1617

or email to

referrals@pacificsleep.com.au

Information

For more information, please call our office on
02 4339 1222

or send us an email at

info@pacificsleep.com.au

or visit our website

www.pacificsleep.com.au