



## Referral Request

Phone: 9451 0522 Fax: 9451 1422

Email: [reception@peninsulasleepclinic.com.au](mailto:reception@peninsulasleepclinic.com.au)

Date:.....

### Patient Details (please complete or attach sticker here)

Name:..... DOB:.....  Male  
Best Contact Phone:.....  Female

### Procedure Requested: *\*Referral from a Sleep Physician only*

- |   |   |
|---|---|
| <input type="checkbox"/> Diagnostic Sleep Study   | <input type="checkbox"/> Dental Device Sleep Study    |
| <input type="checkbox"/> CPAP Titration*  | <input type="checkbox"/> CPAP Review Study            |
| <input type="checkbox"/> Positional Device Sleep Study  | <input type="checkbox"/> Multiple Sleep Latency Test* |
| <input type="checkbox"/> Maintenance of Wakefulness Test*                                       | <input type="checkbox"/> Other (specify):             |
| <input type="checkbox"/> Sleep Physician Consultation - Peninsula Respiratory Group (9975 4911) |   |
| <input type="checkbox"/> Dr Keith Burgess   | <input type="checkbox"/> Dr Stanley Braude            |
| <input type="checkbox"/> Dr Kate Barclay  | <input type="checkbox"/> Dr Linda Seeto               |

### Clinical History/Symptoms:

- |  |  |
|--|--|
| <input type="checkbox"/> Employer or RMS requirement | <input type="checkbox"/> Motor Vehicle Accident    |
| <input type="checkbox"/> Witnessed Apnoea            | <input type="checkbox"/> Hypertension              |
| <input type="checkbox"/> Coronary Heart Disease      | <input type="checkbox"/> Type 2 Diabetes           |
| <input type="checkbox"/> Obesity (BMI>30kg/m2)       | <input type="checkbox"/> Snoring                   |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Arrhythmia                |
| <input type="checkbox"/> Insomnia                    | <input type="checkbox"/> Morning Headache          |
| <input type="checkbox"/> Daytime Sleepiness          | <input type="checkbox"/> Gastro-oesophageal Reflux |
| <input type="checkbox"/> Other (specify):            |  |

### Referring Doctor:

Name:..... Provider Number:.....  
Address:..... Signature:.....  
Report Copies to:.....

# Peninsula Sleep Clinic

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### Appointment Information

- Sleep Studies:** Monday - Thursday Evenings
- Location:** Suite 3, Level 2, Building 1,  
49 Frenchs Forest Rd East, Frenchs Forest NSW 2086
- Office Hours:** Monday - Thursday 8.30am-5pm and Friday 8.30am-3pm
- CPAP Clinic:** Monday, Wednesday, Thursday
- Process:**
1. Fax or email referral request
  2. Peninsula Sleep Clinic will contact the patient to book an appointment
- Reports:** Results are sent to referring doctor within 7-10 days

For more information please visit our website [www.peninsulasleepclinic.com.au](http://www.peninsulasleepclinic.com.au)

