

SLEEP DIAGNOSTICS REFERRAL FORM

Instruction for completion of Referral Form

1. Select initial consultation, or the appropriate diagnostic service if you know which you require.
2. Note whether the referral is urgent or routine.
3. Fill in the referring practitioner's details.
4. Fill in the referred patient's details.
5. Fill in the reason for the referral.
6. If it is urgent or the patient is only in the country for a short time, please list dates available.
7. Return the completed form via post or fax, along with your referral letter.

	URGENT	ROUTINE
Initial Consultation	<input type="checkbox"/>	<input type="checkbox"/>

Diagnostic Services (please tick all that apply)

	URGENT	ROUTINE
Home oximetry	<input type="checkbox"/>	<input type="checkbox"/>
Actigraphy	<input type="checkbox"/>	<input type="checkbox"/>
Home respiratory study	<input type="checkbox"/>	<input type="checkbox"/>
Full polysomnography (PSG)	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sleep Latency Test (MSLT)	<input type="checkbox"/>	<input type="checkbox"/>
CPAP Trial	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Details of Referring Doctor

Date of referral: _____

Name: _____

Practice: _____

Address: _____

Post Code: _____

Tel no: _____

Fax: _____

Email: _____

Details of Patient

Title: _____ Surname: _____

First Name: _____

Date of Birth: _____

Address: _____

Post Code: _____

Tel No: (day) _____

Tel No: (mob) _____

Email: _____

Reason for referral:

Would you like the patient seen by one of our consultants for results? Yes No, I will give results

If the study is urgent, or the patient is only in the country for a short period, please indicate availability:

THANK YOU FOR YOUR REFERRAL