

631 Inkerman Road  
Caulfield North, VIC 3161

Tel 03 9504 8400  
03 9504 8283  
Fax 03 9504 8249

www.medisleep.com.au



**Referral for  
Consultation/  
Sleep Study**

Appointment at 631 Inkerman Road, Caulfield North

on \_\_\_\_\_ time \_\_\_\_\_

**Patient Details**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone H \_\_\_\_\_

W \_\_\_\_\_

M \_\_\_\_\_

**Clinical Factors**

- |                                       |                                               |                                             |
|---------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Snoring      | <input type="checkbox"/> Apnoea               | <input type="checkbox"/> Restless legs      |
| <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Excessive Sleepiness | <input type="checkbox"/> Unrefreshing Sleep |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Type II Diabetes     | <input type="checkbox"/> Cardiac Disease    |
| <input type="checkbox"/> Obesity      | <input type="checkbox"/> Depression/anxiety   | <input type="checkbox"/> COPD               |

**Comorbidities /  
Key Risk Factors**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Referring Doctor**

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_

Provider No. \_\_\_\_\_

**Referral Period**

- 3 months       12 months       Indefinite

**Signature**

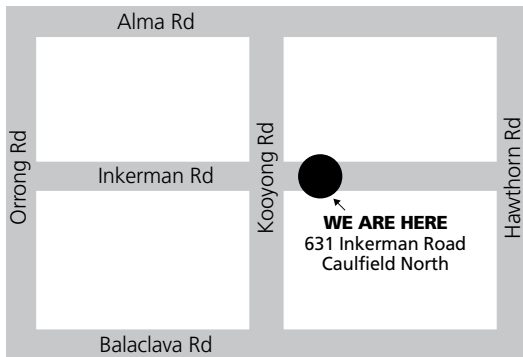
Date    /    /

\_\_\_\_\_

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**Please have your Medicare number  
and Health Fund details ready when  
calling to schedule an appointment.**