REQUEST FOR SLEEP STUDY AND LUNG FUNCTION TESTING

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SURNAME:	Requesting Doctor:
GIVEN NAMES:	Medical Centre:
☐ F ☐ M DOB:	Provider Number:
Phone: Mobile:	☐ Public ☐ Private ☐ DVA ☐ Defence
Email:	Please provide relevant clinical details:
Address:	

- ☐ Sleep Study
- ☐ Full Lung Function Test, incl lung volumes + gas transfers
- ☐ Spirometry - Pre + Post Bronchodilator
- ☐ Six Minute Walk Test
- ☐ Bronchial Provocation (Mannitol Challenge)
- ☐ Overnight Oximetry
- ☐ Rhinomanometry
- ☐ Cardio Pulmonary Exercise Test
- ☐ Exercise Induced Asthma Test
- ☐ Other ....

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ESS: BERLIN: STOPBANG: OSA 50:

Comorbid Conditions:

- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart Disease

Other: ____________

Weight: ____________

BMI: ____________

Priority

☐ Urgent ☐ Semi-urgent

☐ Not Urgent

Does the patient require nursing or special assistance during the test? Please provide details:

CONSULT REQUIRED ☐

RESPIRATORY/SLEEP STUDY ONLY ☐

Requesting Dr. Signature ....

Date requested ....../...../.....

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