Darwin Respiratory and Sleep Health
REQUEST FOR SLEEP STUDY

Ground Floor, Darwin Private Hospital, Rocklands Drive Tiwi NT 0810
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www.darwinsleephealth.com.au

PATIENT DETAILS:

SURNAME:

GIVEN NAMES:

DOB: GENDER: M: ☐ F: ☐

Phone: Mob:

ADDRESS:

PRIVATE HEALTH FUND NAME:

NOT INSURED: ☐ MEDICARE No:

REFERRING DOCTOR:

NAME:

PROVIDER NUMBER:

ADDRESS:

Ph: Fax:

MEMBERSHIP No: DVA: ☐

EXPIRY DATE:

PATIENT PRESENTATION:

SNORING / WITNESSED APNOEAS ☐
EXCESSIVE DAYTIME SLEEPINESS ☐
DAYTIME FATIGUE AND TIREDNESS ☐
OTHER _____

ESS ..... ☐
OSA 50 ..... ☐
BERLIN QUESTIONNAIRE ..... ☐
STOP BANG ..... ☐

STUDY REQUESTED:

DIAGNOSTIC SLEEP STUDY ☐
DIAGNOSTIC SLEEP STUDY with dental device ☐
CPAP TITRATION STUDY ☐
SPLIT NIGHT STUDY (specify split criteria) ☐
MSLT ☐
MWT ☐
OVERNIGHT OXIMETRY ☐
BI-LEVEL TITRATION STUDY ☐
AUTO - PAP TRIAL WITH LIMITED SLEEP STUDY ☐
LIMITED SLEEP STUDY ☐
HOME SLEEP STUDY ☐
AUTO- PAP TRIAL ☐
AMBULATORY BP MONITORING ☐
ACTIGRAPHY ☐
ANY SPECIAL REQUESTS _____

PLEASE PROVIDE RELEVANT CLINICAL DETAILS:

WEIGHT: _____ **KG** **BMI:** _____

COMORBID CONDITIONS:

HYPERTENSION ☐
DIABETES ☐
HEART DISEASE ☐
OTHER.....

DOES THE PATIENT REQUIRE NURSING OR SPECIAL ASSISTANCE DURING THE STUDY?

Yes (please specify):

No ☐

PRIORITY:

URGENT ☐
SEMI-URGENT ☐
NOT URGENT ☐

SLEEP PHYSICIAN CONSULT REQUIRED*

YES ☐ NO ☐

DATE OF REQUEST:

REQUESTING DOCTOR SIGNATURE:

SLEEP PHYSICIAN COMMENTS:

*Please note all patients are referred to Dr Subash Heraganahally (Respiratory & Sleep Physician) unless specified otherwise.

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