

Referral for Assessment / Treatment of Sleep Disordered Breathing		
Practitioner Referral Faxline: 1800 467 049		
Patient's First Name		Male <input type="checkbox"/> Female <input type="checkbox"/>
Patient's Surname		DOB: ___/___/___ dd mm yy
Patient's Phone #1: ()		Patient's Phone #2: ()
Clinical Notes		Observations (if noted)
		Hypertension High BMI Fatigue: General <input type="checkbox"/> Severe <input type="checkbox"/> Chronic <input type="checkbox"/> EDS: (Excessive Daytime Sleepiness) GERD: (Gastro Esophageal Reflux Disease)
Referring Doctor		Provider Number
Clinic / Practice		
Clinic Telephone	()	
Send results and case notes to:	Email:	
	Fax:	()

The Sleep Therapy Clinics – for the professional treatment of sleep disordered breathing
 Practitioner Support Hotline: 1800 467 045
 Practitioner Referral Faxline: 1800 467 049