

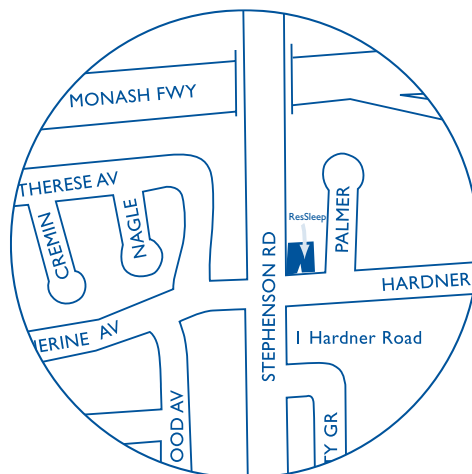
ONE OF THE LONGEST ESTABLISHED SLEEP APNOEA CLINICS IN MELBOURNE (LOCATED AT THE SAME TRUSTED ADDRESS)

- Specialists Australia-wide in delivering high level treatment services for Sleep Apnoea, Complex Sleep Apnoea and COPD
- Implementation of CPAP/APAP treatment trials for patients with known sleep apnoea
- Implementation of pressure/treatment reviews for patients currently using an APAP/CPAP device
- Complex Sleep Apnoea assessment/treatment trials for patients with known Complex Sleep Apnoea
- VPAP[®] treatment trials/reviews
- Educationals on snoring, sleep apnoea and sleep hygiene (for any patient requiring further information)
- Overnight ambulatory investigation for Sleep Apnoea
- Medicare approved
- Supervised by local sleep physicians
- Access to local sleep physicians for patients requiring consultations

Appointment

Date _____

Time _____



Referral Form

Please contact ResSleep to make an appointment.

Please ensure that this referral is presented to ResSleep at time of consultation.

CLINICAL NOTES

Patient name _____ Tel _____

Patient symptoms (tick appropriately)

- Snoring
- Witnessed Apnoeas / Nocturnal gasping / choking
- Daytime Lethargy/Sleepiness

Relevant Medical Conditions (tick appropriately)

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke /TIA |
| <input type="checkbox"/> Type II Diabetes | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Cardiac Failure | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Other _____ |

Additional clinical history _____

REQUEST FOR (tick appropriately)

- Home diagnostic sleep study – for suspected Obstructive Sleep Apnoea
- Home diagnostic sleep study followed by Sleep Physician consultation
- CPAP/AutoSet[®] treatment trial – for known Obstructive Sleep Apnoea
- VPAP Adapt[®] treatment trial – for known Complex Sleep Apnoea
- VPAP[®] S/ST/ST-A treatment trial – for known COPD or _____
- Pressure/treatment review

Commercial Licence Yes No

REQUESTING DOCTOR

Name _____ Signature _____

Date of referral _____ Period of referral 3month 12 months indefinite

Provider No. _____ Copies to _____

Upon receipt of this referral:

1. We will contact your patient and arrange for an overnight sleep study or treatment trial.
2. Your patient's diagnostic sleep report will be forwarded to you.