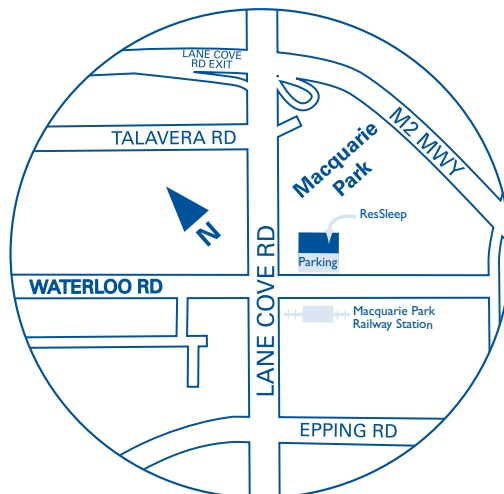


# YOUR TOTAL SLEEP APNOEA SERVICES AT THE SAME ADDRESS IN THE NORTH SHORE/RYDE AREA



- 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 suspected sleep apnoea
- Implementation of pressure/treatment reviews for patients currently using an APAP/CPAP device
- Complex Sleep Apnoea assessment/treatment trials for patients with suspected Complex Sleep Apnoea
- 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 post study follow up



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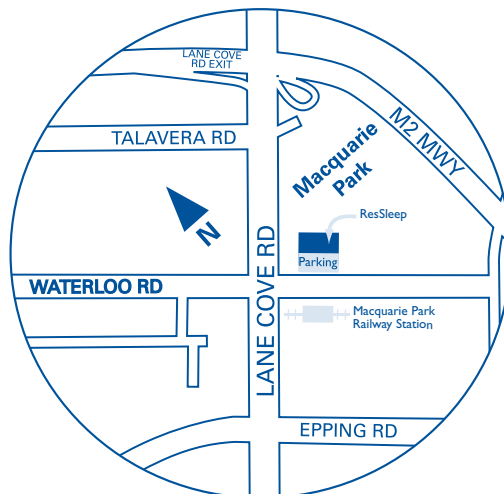
## Appointment

Date

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Time

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# 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 (Please tick the appropriate box)

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

Relevant Medical Conditions (tick appropriately)

- Hypertension                       Stroke / TIA
- Type II Diabetes                       Obesity
- Cardiac Failure                       COPD
- Atrial Fibrillation                       Other \_\_\_\_\_

Clinical history (optional) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REQUEST FOR (Please tick the appropriate box)

- Home diagnostic sleep study (conducted by Somnyx Sleep Diagnostics)
- CPAP/AutoSet® treatment trial – for suspected Obstructive Sleep Apnoea (conducted by ResSleep)
- VPAP Adapt® treatment trial – for suspected Complex Sleep Apnoea (conducted by ResSleep)
- VPAP® S/ST/ST-A treatment trial – for suspected COPD or patients requiring pressure-assisted breathing (conducted by ResSleep)
- Pressure/treatment review with oximetry (conducted by ResSleep)

Commercial Licence Yes  No

## REQUESTING DOCTOR

Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ 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.