



**Referral † to:**  
 Dr David Hillman - FANZCA (Director)  
 Dr Bhajan Singh - FRACP  
 Dr Alan James - FRACP  
 Dr Rodney Steens - FRACP  
 Dr Stewart Cullen - FRACP  
 Dr Nigel McArdle - FRACP  
 Dr Scott Claxton - FRACP

- 1<sup>st</sup> Available appointment  
 or  
 Preferred specialist \_\_\_\_\_

† All services and investigations are billed for all patients

To assign priority, it is necessary to complete this form and return it to the Sleep Disorders Clinic before an appointment can be arranged. Thank you.

PATIENT DETAILS		REFERRING DOCTOR	
NAME		NAME	
ADDRESS		ADDRESS	
	POSTCODE		
DOB / /	SEX Male / Female		POSTCODE
Ph: (H) (B)		Ph:	E-mail:
Mobile:		FAX:	DATE / /
HT: cm WT: kg		<b>REFERRAL PERIOD Indefinite / months</b>	
MEDICARE NO		SIGNATURE	
PENSIONER / HEALTH CARE CARD / DVA YES / NO			
(Please circle)		PROVIDER NUMBER	

CLINICAL PROBLEM / REASON FOR REFERRAL	(Attach separate referral letter if more space required)

CURRENT OCCUPATION (May influence priority for consultation)	
--	--

SPECIFIC PATIENT SYMPTOM INFORMATION			
	YES	NO	Details/Comments
<b>Driving/Employment affected by sleepiness/fatigue?</b> (eg dozing at lights, running off road, recent MVA)	<input type="checkbox"/>	<input type="checkbox"/>	_____
			_____

COMORBIDITIES Have any of the following conditions been diagnosed in this patient? (please tick)			
<input type="checkbox"/> Obstructive Lung Disease eg severe COPD, asthma	<input type="checkbox"/> Vascular Disease* eg CVA, TIA	<input type="checkbox"/> Peripheral Oedema (right heart failure)	
<input type="checkbox"/> Chest Wall Disease* eg kyphoscoliosis	<input type="checkbox"/> Cardiac Failure	<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Hypercapnic Respiratory Failure ↑ arterial CO <sub>2</sub>	<input type="checkbox"/> Ischaemic Heart Disease	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Neuromuscular Disease*	<input type="checkbox"/> Morbid Obesity (BMI >50)	<input type="checkbox"/> Other*	

\* Specify \_\_\_\_\_

**MAIL OR FAX COMPLETED FORM TO:**

Respiratory Sleep Disorders Clinic Internal Mailbox 201 Queen Elizabeth II Medical Centre Hospital Avenue NEDLANDS WA 6009	Tel: (08) 9346 2422 Fax: (08) 9346 2822
--	--