RHC100.14
Admission Referral

Beleura Private Hospital
Part of Ramsay Health Care

Sleep Centre Booking Form

Unit Record Number

Surname

Given Names

Date of Birth

Sex

Room No.

Doctor

OR USE PATIENT LABEL

Fax Completed Form to 03 5975 9144

PATIENT DETAILS

Title: _____ Surname: _____ Given Names: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Phone: (H) _____ (M) _____

Medicare Number: _____ Reference Number: ____

Health Fund Name: _____ Health Fund Number: _____

STUDY REQUESTED

☐ Diagnostic sleep study
☐ CPAP implementation study
☐ CPAP review study

Reason for sleep study referral

☐ Snoring ☐ Fragmented sleep ☐ Restless legs ☐ Hypertension(on>2 meds)
☐ Witnessed apnoeas/gasping ☐ Wakes unrefreshed ☐ Abnormal sleep behaviour ☐ ?Hypoxia o'night
☐ Daytime sleepiness ☐ Insomnia ☐ Pre operative assessment (may require O_2)

☐ Other: _____

Past medical history

Obstructive sleep apnoea risk factors;

☐ Obesity ☐ Hypertension ☐ Depression ☐ Diabetes

☐ Ischaemic heart disease ☐ Lung disease ☐ Cardiomyopathy/CCF ☐ Hypothyroidism

☐ Cerebrovascular disease ☐ Cognitive impairment ☐ Suspected respiratory failure ☐ Atrial fibrillation

☐ Other: _____

Relevant Medications:

Referring Doctors Details:	**Aditional Reports to:**
Name of referring Doctor:	**Name:**
Provider Number: **Date:** / /	**Address:**
Referring Doctor Signature:	

BINDING MARGIN - DO NOT WRITE

SLEEP CENTRE BOOKING FORM

MR 391