Suite 23, Peninsula Specialist Centre

101 George Street, Kippa-Ring QLD 4021

Ph: 07 3488 8197

Email: [info@sleepconnect.com.au](mailto:info@sleepconnect.com.au)

# REFFERAL FORM

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | |
| Name: | | | DOB: |
| Address: | | | Postcode: |
| Tel: | | | Mobile: |
| Email: | | | |
| **CLINICAL INFORMATION** | | | |
| Diagnosis: | AHI: | | ESS: |
| **TREATMENT SETTINGS** | | | |
| □ Initiation of treatment □ Treatment adjustment | | | |
| □ CPAP | □ BILEVEL | | □ ASV |
| □ Fixed…………………cmH2O  □ Auto …………………cmH2O | IPAP………………………cmH2O  EPAP …………………….cmH2O  Rate ……………………..bpm | | EPAP ……………..….…cmH2O  Swing ……………………cmH2O  Rate …………………….bpm |
| Notes & Other settings: | | | |
| Mask: | | | |
| **PRESCRIBER** | | | |
| Name: | | | |
| Clinic Name: | | | |
| Address: | | | Postcode: |
| Tel: | | Fax: | |
| Email: | | Provider  Number: | |
| Communication by □ email □ post □ fax | | | |
| Signature: | | | Date: |