☐ 1st Available appointment
or
☐ Preferred specialist_____

Referral † to:
Dr David Hillman - FANZCA **(Director)**
Dr Bhajan Singh - FRACP
Dr Alan James - FRACP
Dr Stewart Cullen - FRACP
Dr Nigel McArdle - FRACP
Dr Sutapa Mukherjee - FRACP
Dr Richard Warren – FRACP
Dr Jeanie Leong – FRACP
Dr Scott Phung – FRACP
Dr Sina Keihani – FRACP
† 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	REFERRAL PERIOD **Indefinite ❒/ _____months ❒**
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
Driving/Employment affected by sleepiness/fatigue? *(eg dozing at lights, running off road, recent MVA)*	❒	❒	_____ _____

COMORBIDITIES *Have any of the following conditions been diagnosed in this patient? (please tick)*

❒ Obstructive Lung Disease eg severe COPD, asthma	❒ Vascular Disease* eg CVA, TIA	❒ Peripheral Oedema (right heart failure)
❒ Chest Wall Disease* eg kyphoscoliosis	❒ Cardiac Failure	❒ Hypertension
❒ Hypercapnic Respiratory Failure ↑ arterial CO_2	❒ Ischaemic Heart Disease	❒ Diabetes
❒ Neuromuscular Disease*	❒ Morbid Obesity (BMI >50)	❒ Other*

* Specify

✉ MAIL OR FAX COMPLETED FORM TO:

Respiratory Sleep Disorders Clinic
Internal Mailbox 201
Queen Elizabeth ll Medical Centre
Hospital Avenue
NEDLANDS WA 6009

Tel: (08) 9346 2422
Fax: (08) 9346 2822
Website: www.wasdri.org.au

West Australian Sleep Disorders Research Institute (Inc)