

Referral Paediatric Sleep Study



Patient Details

Name Date of Birth

Parent/Caregiver Names:

Address

Phone (Home) (Work) (Mobile)

Email

Indication for Sleep Study:

- | | | |
|--|--|--|
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Hypoventilation | <input type="checkbox"/> Periodic limb movements/Restless legs |
| <input type="checkbox"/> Excessive day time sleepiness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Parasomnia |
| <input type="checkbox"/> Other | | |

Clinical Notes:

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Referring doctor details

Name Provider No

Address

Signature Date

Accredited Paediatric Sleep Physician Yes No

FAX FORM to:

03 9805 4306

EMAIL FORM to:

info@teddybearsleepservices.com.au

Children need to be assessed by a paediatric sleep physician before proceeding to a sleep study.

A/Prof Margot Davey

Provider No 033396AT

Appointments :

Clayton

phone 03 9594 2900 fax 03 9594 6224

East Melbourne

phone 03 9417 5113 fax 03 9417 5114