

# Sleep Study Request

**Sleep Study Request**  
Enquiries: 03 9501 8868

## Referrals accepted via:

E [vicrehab.sleep@healthscope.com.au](mailto:vicrehab.sleep@healthscope.com.au)  
F 03 9566 2848



## Patient Details

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	Other:	Surname:	Given Name(s):
Date of Birth:				Weight:	Height:
Address:				Post Code:	
Home Phone:		Work Phone:		Mobile:	
Email:		Health Fund:		Health Fund Number:	

## Clinical Details

Please indicate your reasons for referral:

Other relevant medical conditions:

Please indicate your reasons for referral:

Mobility:  Assisted walking    Wheelchair bound    Independent      Clinically Urgent:  No    Yes

## Study Type

Diagnostic    CPAP Implementation    CPAP Review    Split Study    MAS    MSLT    MWT

Study Date: \_\_\_\_\_ Follow-up Date: \_\_\_\_\_

## Referring Doctor's Details

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date: \_\_\_\_\_

Provider Number: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

## Additional sleep study reports to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

### The Victorian Rehabilitation Centre

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[thevictorianrehabilitationcentre.com.au](http://thevictorianrehabilitationcentre.com.au)

ABN 61 069 962 698