Beenleigh SLEEP CLINIC

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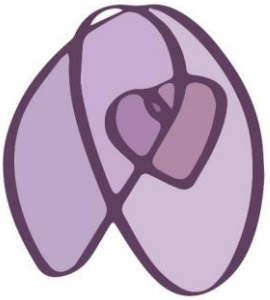
Dr John F E Feenstra

THORACIC & L2
SLEEP PHYSICIAN



Sleep Test Referral

Ambulatory Home Sleep Test

Patient Information

Surname		D.O.B.		☐ Male	☐ Female
Given Names					
Address				Postcode	
				Phone	
Medicare No				Private health insurance ☐ Yes	☐ No

Indications, Symptoms and Health Comorbidities

Please check where applicable

- ☐ Disruptive snoring
- ☐ Apnoea, choking or gasping
- ☐ Insomnia or awakenings
- ☐ Bruxism
- ☐ Nightmares or morning headaches
- ☐ Nocturia – excessive
- ☐ Periodic leg movements (PLMS, RLS)
- ☐ Other: *Please specify* _____

- ☐ Daytime sleepiness or excessive fatigue
- ☐ Broken, restless or unrefreshing sleep
- ☐ Obesity
- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart disease or CCF
- ☐ Arrhythmia or palpitations
- ☐ Sleepy or drowsy driving

Telehealth Consultation ☐ Yes ☐ No

Referring Doctor

Date		Provider No.	
Name			
Address			
		Postcode	
Phone		Fax	
Email		Signature	

***Report Preference*:** Mail ☐ Fax ☐ Email ☐