NATIONAL CLINICAL SERVICES

NEW ENGLAND
NORTH WEST
CENTRAL WEST
SOUTHERN SYDNEY
SOUTHERN HIGHLANDS

Ph: 1300 301 639 | Fax: 1300 301 936
E: info@ncservices.com.au

REFERRAL FORM

Reporting Respiratory Physicians
Dr Stephen Cala M.B., B.S., FRACP, PhD
Dr Michael Hayes M.B., B.S., FRACP
Dr Chris Duggan M.B., B.S., FRACP

Reporting Cardiologist
Dr Suchitra Chandar MBBS PhD FRACP FCSANZ

Patient Name: _____ Medicare No: _____

Date of Birth: _____ Tel: _____ Mob: _____

Residential Address: _____

Clinical Notes: _____

_____

SLEEP APNOEA

Please assess clinical probability of Obstructive Sleep Apnoea and if appropriate arrange for:
(Please tick the appropriate box/boxes)

- ☐ Home Diagnostic Sleep Study
  (oximetry, airflow, respiratory effort, ECG)
- ☐ Implement Sleep System Treatment Trial
  (machine, mask & review consultations)
- ☐ Annual Treatment Review
  (oximetry, CPAP Pressure, compliance/effectiveness)

ADDITIONAL DIAGNOSTICS

- ☐ 24 Hr Holter Monitoring
- ☐ 24 Hr BP Monitoring*
- ☐ Implement O2 Therapy @ ___ L/m
- ☐ Spirometry*
- ☐ Overnight Oximetry

**may not be available at all clinics*

Requesting Doctor:

Name: _____ Provider Number: _____

Tel: _____ Fax: _____

Signature: _____ Date: _____

Cc: _____

Please fax or email referral and our staff will contact the patient with the next available appointment.