

**MITCHAM**  
**PRIVATE HOSPITAL**

27 Doncaster East Road Mitcham Vic 3132  
Ph: (03) 9210 3224 Fax: (03) 9210 3290

**REQUEST FOR SLEEP STUDY**

Unit Record Number:

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

Given Names: \_\_\_\_\_

Date of Birth:

Age:

Sex:

**OR USE LABEL**

Mrs  Mr  Ms  Miss

D.O.B: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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

Street: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Referred by: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Provider Number: \_\_\_\_\_ Referral Date: \_\_\_\_\_

**ADMITTING DOCTOR (print name):** \_\_\_\_\_

**Admission Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Review Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Do you want to be called if we have an earlier appointment?

Clinically urgent studies?

TYPE OF STUDY	EXISTING DISORDERS
<input type="checkbox"/> Diagnostic	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Repeat Diagnostic	<input type="checkbox"/> Diabetes
<input type="checkbox"/> CPAP Implement	<input type="checkbox"/> Neurological Disorders
<input type="checkbox"/> CPAP Review (current pressure): _____	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Post-operative (ie UPPP)	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> M.A.S	<input type="checkbox"/> Asthma
<input type="checkbox"/> M.S.L.T	<input type="checkbox"/> _____
<input type="checkbox"/> _____	

**REASON FOR TEST / RELEVANT HISTORY / SPECIAL INSTRUCTIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Order sedation if required: \_\_\_\_\_

Adjust CPAP machine pressure following the CPAP Review Study

For bookings and clinical concerns, please contact Mitcham Sleep Centre on **9210 3224**

Please fax request form to **9210 3290**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_