

# SLEEP SA

The Memorial Hospital

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## POLYSOMNOGRAPHY REQUEST FORM

### PATIENT DETAILS

Surname: \_\_\_\_\_ Given Name(s): \_\_\_\_\_  
Address: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Email: \_\_\_\_\_  
Telephone: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mob): \_\_\_\_\_  
Study Date: \_\_\_/\_\_\_/\_\_\_ **Follow-up Date:** \_\_\_/\_\_\_/\_\_\_ by: \_\_\_\_\_  
Health Fund: \_\_\_\_\_ Fund No: \_\_\_\_\_ Medicare No: \_\_\_\_\_

### CLINICAL DETAIL

### INSTRUCTIONS TO TECHNICAL STAFF

### TEST REQUIRED

- Diagnostic  
 CPAP Titration  
 Other \_\_\_\_\_

### LEVEL OF ASSISTANCE / NURSING CARE REQUIRED OVERNIGHT

### REFERRING DOCTOR'S DETAILS

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

### ADDITIONAL COPIES TO

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

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

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