PAEDIATRIC SLEEP STUDY REQUEST FORM

Health Dynamics Tasmania

HealthLink ID: hlthdtas
Fax: 03 4206 7880
Email: info@healthdynamics.com.au

Patient details:

Name: _____ DOB: _____ / _____ / _____

Address: _____

Post code: _____ Telephone: _____

Guardian name: _____ Email: _____

Reason for sleep study / Relevant background history:

_____
_____
_____
_____
_____

□ **Telehealth consultation only (with Dr Burgess)**

□ **Home sleep study (3y and older) and telehealth consultation**

Referring doctor details:

Name: _____

Address: _____

Provide number: _____ Signature: _____

Date of referral: _____ / _____ / _____

Dr Scott Burgess MBBS PhD FRACP, Paediatric Sleep Physician

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