PATIENT REFERRAL FORM

SleepWise CLINIC

Patient Details

Date

Name DOB

Address

State Postcode

Tel Email

Reason for referral

Chief Concerns / Symptoms

- ☐ Snoring
- ☐ Daytime sleepiness
- ☐ Unrefreshed sleep
- ☐ Choking or gasping
- ☐ Bruxism
- ☐ Witnessed apnoeas
- ☐ Other (please specify)

Relevant Medical History

- ☐ Hypertension
- ☐ Heart disease
- ☐ Diabetes
- ☐ Other (please specify)

Referred by

Name

Tel Email

Address

State Postcode

Dr Harry Ball
BDSc LDS (Melb) M Counselling (Lat)
Grad Dip Counselling & HS (Lat)

Dr Ken Lee
BHSc(Dent), MDent

Dr Sue Lim
BHSc(Dent), MDent

Dr Sam Talpis
BOH.DSc(QLD),
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Dr Ben Abbott
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Dr Krystel Ho Skilton
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Dr Patricia Hanna
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Dr Jonti Nolan
DDS (Melb) B.Sc (Melb)