Referral Paediatric Sleep Study

Patient Details

Name ..... Date of Birth .....

Parent/Caregiver Names: .....

Address .....

Phone (Home) ..... (Work) ..... (Mobile) .....

Email .....

Indication for Sleep Study:

- ☐ Obstructive Sleep Apnea
- ☐ Hypoventilation
- ☐ Periodic limb movements/Restless legs
- ☐ Excessive day time sleepiness
- ☐ Insomnia
- ☐ Parasomnia
- ☐ Other .....

Clinical Notes:

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Referring doctor details

Name ..... Provider No .....

Address .....

Signature ..... Date .....

Accredited Paediatric Sleep Physician ☐ Yes ☐ No

FAX FORM to:
03 9804 3688

EMAIL FORM to:
info@teddybearsleepservices.com.au

Children need to be assessed by a paediatric sleep physician before proceeding to a sleep study.

Dr Margot Davey
Provider No 033396AT

Appointments:
Clayton
phone 03 9594 2900 fax 03 9594 6224
East Melbourne
phone 03 9417 5113 fax 03 9417 5114

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