DENTAL SLEEP CLINIC
AUSTRALIA
Snoring and Sleep Apnoea Solutions

PATIENT REFERRAL

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PATIENT DETAILS

First Name: ______________________ Surname: ______________________

Address: ______________________

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Phone: ______________________ Date of birth: ______________________

REQUEST FOR

- ○ Mandibular advancement splint
- ○ Consultation Snoring/Obstructive Sleep Apnoea
- ○ MAS trial/alternative to CPAP
- ○ Other(please specify)

CLINICAL DETAILS

Chief Concerns / Symptoms (Please Tick)

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

REFERRING PRACTITIONER

Name: ______________________

Address: ______________________

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Telephone: ______________________

Signature: ______________________ Date: ______________________

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www.dentalsleepclinicaustralia.com.au