LungHealth Australia
PO Box 63, Kellyville, NSW, 2155
t: 1300 874 325
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Polysomnography Request Form

PATIENT DETAILS					
First Name		Surname		Gender	M / F
Phone No:		Mobile:		Date of birth	
Address					
Private health fund	Yes / No	Pension/Health care card	Yes / No	DVA	Yes / No

CLINICAL HISTORY			
Snoring	☐	Witnessed apnoeas / gasping during sleep	☐
Daytime sleepiness	☐	Work performance adversely affected	☐
Public transport or commercial vehicle / machinary driver			☐
Motor vehicle accident related to sleepiness in the past five years			☐
Pre surgery (Provide details)			

TESTS REQUESTED			
Diagnostic sleep study	☐	CPAP titration (with autosetting CPAP)	☐
Other _____			

Follow up post polysomnography			
Please arrange follow up with next available sleep physician			☐
Follow up not required	☐	Please arrange follow up with Dr _____	

REFERRAL DETAILS			
Provider Name:		Provider No:	
Address			
Email / Fax (for report)		URGENT	Yes / No
Signature		Date	____/____/____
Copies to			