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 Ken Lee
BHSc(Dent), MDent

Dr Sue Lim
BHSc(Dent), MDent

Dr Sam Talpis
BOH.DSc(QLD),
G.Dip Dent (QLD)

Dr Ben Abbott
BDSc (UWA)

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