Adelaide Institute *for* **Sleep Health**
Improving health through the *science of sleep.*

Polysomnography *Request Form*

Sleep/Respiratory Consultant's Name and Address:

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Number of Report copies required: ( )

Referring Doctor Details: (mandatory information)

Name: .....

Date of Referral: ..... /..... /.....

Address or Provider No: .....

.....

Date of Study: ..... / ..... / ..... **Date of Follow Up:** ..... / ..... / .....

PATIENT DETAILS:

Surname: ..... Given Names: .....

Date of Birth: ..... / ..... / ..... Sex: ☐ Male ☐ Female

Hospital File Number: RGH ..... FMC: .....

Address: ..... Postscode: .....

Telephone: (H) ..... (W) ..... (M) .....

Private Patients (covered for overnight admission):

Health Insurer: .....

Membership No.: .....

Excess: $ ..... Medicare No.: .....

Public Patients:

Medicare No./ DVA: .....

Pensioner/Health Care Card No.: .....

PROVISIONAL DIAGNOSIS:

TEST REQUIRED:

- ☐ Diagnostic Polysomnography (PSG) ≥ 18 years of age
- ☐ Diagnostic Polysomnography (PSG) < 18 years of age
- ☐ CPAP Titration
- ☐ Sleep Institute Clinical Review
- ☐ Multiple Sleep Latency Test (MSLT)
- ☐ Maintenance of Wakefulness Test (MWT)
- ☐ Home Autoset Titration (APAP)
- ☐ Ambulatory Diagnostic Polysomnography (PSG)
- ☐ Other (Specify) .....

Important additional patient information required:

- ☐ $TcCO_2$
- ☐ Video Monitoring
- ☐ Extended EEG
- ☐ Extended EMG

Special assistance (e.g. transferring to bed, turning during the night): ☐ YES ☐ NO

IF YES PLEASE SPECIFY:

Other clinical details/requests:

Study requested by: ..... **Signed:** ..... **Date:** ..... / ..... / .....

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