Dr. Andrew Rosenstengel
RESPIRATORY AND SLEEP PHYSICIAN

Referral Form

Please fill in the following information:

Patient Details	
Patient Name:	
Date of Birth: (D/M/Y)	Home Phone:
Email:	Mobile:
Address:	
Clinical History:	

☐ **Respiratory** *(please ✓ tick)*	☐ **Sleep** *(please ✓ tick)*
☐ Suspected lung cancer	☐ Snoring
☐ Pulmonary nodule	☐ Obstructive sleep apnoea
☐ Asthma	☐ Restless legs syndrome
☐ COPD	☐ Central sleep apnoea
☐ Bronchiectasis	☐ Other
☐ Cough	
☐ Pleural disease	**Sleep Tests:**
☐ Pulmonary Hypertension	Diagnostic sleep study already performed: ***Yes / No***
☐ Other	CPAP study already performed: ***Yes / No***

Referring Doctor Details	
Name:	Provider Number:
Practice Name:	Address:
Contact Number:	Date: (D/M/Y)
Notes:	

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