

# REFERRAL FORM

Phone: 0800 22 75 33  
Fax: 0800 22 75 44  
Email: doctor@sleepwellclinic.co.nz  
Website: www.sleepwellclinic.co.nz



Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

## REASON(S) FOR REFERRAL

Snoring/Sleep Apnoea

CPAP

Insomnia

Child/Baby Sleep Difficulites

Parasomnia *e.g. Sleepwalking, Night terrors, Nightmares, Restless Leg Syndrome*

Shift work

Daytime Fatigue

Other \_\_\_\_\_

Clinical information or attached report letter...

\_\_\_\_\_

\_\_\_\_\_

Medication: \_\_\_\_\_

\_\_\_\_\_

## REFERRING PRACTITIONER'S

Stamp/Address:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_