

MULTI-DISCIPLINARY SLEEP CLINIC REFERRAL

Affix patient label or fill details below:

Name:	NHI:
Email:	Date of birth:
Address:	Phone:

Please select all that apply:

- Multi-Disciplinary Team review: *complex sleep issues*
- Sleep/Respiratory Physician assessment: *narcolepsy, parasomnia, RLS, OSA*
- Sleep Surgeon assessment: *nose, sinuses, snoring, OSA*
- Sleep Strong: *personal training, nutrition, weight management, sleep coaching*
- Psychotherapy: *depression, anxiety, stress*
- Physiotherapy: *bruxism, grinding, myo-fascial pain, TMJ, chronic pain*
- Behavioural Therapy: *Insomnia, COMISA (co-morbid insomnia and sleep apnoea)*
- Custom-made mandibular advancement device: *snoring or OSA*

- Home-based screening sleep study
- Home-based comprehensive sleep study
- In-lab comprehensive sleep study
- CPAP trial

After assessments/investigations:

- Please return the patient to my care
- Discuss and organise further management with the patient

Additional information

Referrer details

Name:	Date:
Phone:	Email:
Practice:	

Please scan and email form to contact@aucklandsleep.co.nz

*Please ensure that the patient completes our practice form at:
<https://aucklandsleep.co.nz/newraf> (they can use this QR code)*

