

Sleep Disorders Centre Referral

Level 2F, Princess Alexandra Hospital Ipswich Rd, WOOLLOONGABBA. Q. 4102.

Tel: (07) 3176 5751 Facsimile: (07) 3176 7096 Email: sleeplab@health.gld.gov.au

Patient Details: Name: Address:		Intermediate Referral [†] Dr John Armstrong Dr Craig Hukins Dr Khoa Tran Dr Luke Garske	
Tel:	(H) (B) (Mob)		Dr Michelle Murphy Dr Geoff Eather
DOB: / / Medicare number:	UR Number:		† All services and investigations are Bulk-billed
Reason For Referral / Clinical Details:			
☐ Sleep investigations / studies p	performed elsewhere. Please	e attach c	opies of full results.
Specific Information: Significant Co-morbidities:			
Effects on Driving:			
Occupation:			
Referring Doctor: Name:			
			atient will be notified of the appointment by mail.
Signature:		Please (07) 3	e forward by facsimile 3176 7096 or by mail
Provider number: Date:/ Referral Period: Email address:	Indefinite or months	SDC Use Category Date ente Appointm	VU / U / SU / R ered / /