GAWLER Sleep Clinic

Sleep Health
CPAP Specialist

CLIENT DETAILS

CONTACT DETAILS

FIRST NAME _____ DOB ____/____/_____

SURNAME _____

ADDRESS _____

_____

_____ STATE _____ POSTCODE _____

EMAIL _____

PHONE _____

MEDICARE NUMBER _____ REF _____

PERSONAL INFORMATION

Which of the following best describes you? (Please tick any that apply):

- ☐ I have been referred for a diagnostic Sleep Study by my GP or other health professional.
- ☐ I have been prescribed CPAP therapy by my GP or other health professional.
- ☐ I am an existing CPAP User.
- ☐ I am interested in improving my sleep quality / seeking information.
- ☐ Other: _____

- Have you had a Home-Based Sleep Study in the past 12 months? ☐ YES ☐ NO

REFERRING DOCTOR (IF APPLICABLE)

DOCTOR'S NAME _____

ADDRESS _____

_____

_____ STATE _____ POSTCODE _____

PRIVACY STATEMENT

I, _____ , CONSENT / DO NOT CONSENT to the disclosure and dissemination of my personal health information to my nominated carers, including the referring Doctor, Supervising/Reporting technician, Sleep technician, Sleep clinician and any Administrative personnel nominated by Gawler Sleep Clinic, for the sole purpose of diagnosing and/or treatment of my suspected/diagnosed Sleep Disorder.

SIGNED _____DATE: ____ /____/_____