SLEEP PSYCHOLOGY
PATIENT REFERRAL FORM

Date

☐ Patient consents to being contacted directly

Patient Details/Sticker

Name

Address

DOB

Medicare #

Phone

Email

REASONS FOR REFERRAL (tick all that apply)

Please choose one (medicare)

- ☐ Assessment only
- ☐ CBT-i for insomnia
- ☐ CPAP adherence support
- ☐ Other Sleep Psych management

Sleep Behaviours

- ☐ Poor sleep habits
- ☐ Sleep-related anxiety
- ☐ Stress affecting sleep
- ☐ Racing thoughts at bedtime

Circadian & Lifestyle

- ☐ Shift work
- ☐ Delayed sleep phase
- ☐ Circadian rhythm disorder

Mental Health & Medical

- ☐ Chronic pain
- ☐ Anxiety
- ☐ Depression
- ☐ Nightmares

Support for Existing Sleep Disorder

- ☐ CPAP intolerance/support
- ☐ Fatigue despite treatment
- ☐ Sleep apnoea with persistent symptoms
- ☐ Hypersomnia/Narcolepsy

Other

New Sleep
Suite 12, 69 Parry St, Newcastle West, 2302

T: 02 5007 5337
E: admin@newsleep.com.au

REFERRAL TYPE (choose one)

- ☐ ***Mental Health Care Plan***
  - ☐ 6 appointments
  - ☐ 4 appointments
- ☐ ***Workcover/SIRA***

Claim number

Injury Date

- ☐ ***Private patient***
- ☐ ***Chronic Disease Management Plan***

Number of appointments (max 5)

- ☐ ***DVA***

☐ Gold ☐ White

Card Number

PLEASE ATTACH (those that apply)

- ☐ Sleep Study
- ☐ Medication list
- ☐ CPAP download
- ☐ Relevant letters
- ☐ Mental Health Care Plan
- ☐ Chronic Disease Management Plan

ADDITIONAL COMMENTS

REFERRER

Name

Practice

Provider No.

Phone

Signature

(medicare requirement)