SLEEP BETTER
MANCHESTER

Sleep Clinic Referral Service

Patient's details

Name..... Date of birth.....

Address.....

..... Postcode.....

Phone number ..... Email.....

Nature of sleep problem

Please include any relevant medical history

Please indicate

Has the patient been diagnosed with sleep apnoea? Yes ☐ No ☐

Have there been any witnessed waking gasps or choking episodes? Yes ☐ No ☐

Do they wake feeling unrested? Yes ☐ No ☐

Has a sleep test been carried out? Yes ☐ No ☐

Do they require a sleep test? Yes ☐ No ☐

Referring practitioner's details

Name.....

Practice name & address.....

..... Email.....

Signature..... Date.....

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