



Referral form

Patient Details

Date: _____

Name: _____ DOB: _____

Address: _____

State: _____ Postcode: _____

Email: _____ Tel: _____

Reason For Referral:

Chief Concerns/Symptoms:

- | | | |
|--|---|---|
| ☐ Snoring | ☐ Daytime Sleepiness | ☐ Unrefreshed Sleep |
| ☐ Choking or Gasping | ☐ Bruxism | ☐ Witnessed Apnoea's |
| ☐ Other (Please specify): _____ | | |

Relevant Medical history:

- | | | |
|--|--|-----------------------------------|
| ☐ Hypertension | ☐ Heart disease | ☐ Diabetes |
| ☐ Other (Please specify): _____ | | |

Referred by:

Name: _____

Tel: _____ Email: _____

Address: _____

State: _____ Postcode: _____

Dr. Daniel Craig Hetrelezis

DDS (Melbourne)

Tasmania Snoring & Sleep Oral Appliance Centre

4/21 Vermont Road, Mowbray, TAS 7248

Launceston | St Helens

(03) 6326 4368

www.sleeptasmania.com.au

Dr. Melissa Murray

BDS (Usyd) – Honours

Sydney Snoring & Sleep Apnea Oral Appliance Centre

Sydney Sleep Centre, inside Garners Dental,
51 Garners Avenue, Marrickville NSW

Sydney

(02) 9569 3378 (Garners)

www.sydneysleepcentre.com.au