QLD DENTAL SLEEP THERAPY

DR. ADAM TEO

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REFERRAL FORM

Please email to reception@qdst.com.au or fax to 07 3041 5014

PATIENT DETAILS			
Name:		Date of Birth:	__ / __ / _____
Address:			
		Postcode:	
E-Mail:		Phone:	

SLEEP STUDY DIAGNOSIS *(please attach a copy of sleep study results)*

☐	Mild	☐	Moderate	☐	Severe	☐	CPAP Intolerant

PLEASE LIST ANY FURTHER CONSIDERATIONS OR APPLIANCE PREFERENCES:

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REFERRING DOCTOR DETAILS			
Name:			
Signature:		**Date:**	

North Lakes: The Headache, Neck & Jaw Clinic, 17/12-18 Discovery Drive, Q 4509

Nundah: The Headache, Neck & Jaw Clinic, 2/1471 Sandgate Road, Q 4012

Keperra: Keperra Dental Surgery, Great Western Super Centre
Corner Settlement and Samford rds, Keperra Q 4054

Greenslopes: The Headache, Neck & Jaw Clinic, 158 Juliette Street, Q 4120