QLD DENTAL SLEEP THERAPY

DR. ADAM TEO

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REFERRAL FORM

PATIENT DETAILS

Name:		Date of Birth:	__/__/____
Address:			
		Postcode:	
E-Mail:		Phone:	

I AM REFERRING MY PATIENT FOR:

- ☐ MAS therapy for snoring/OSA treatment *(Please provide sleep study results)*
- ☐ Bruxism
- ☐ TMJ concerns

OTHER RELEVANT INFORMATION:

REFERRING DOCTOR DETAILS

Name:		Provider No:	
Signature:		**Date:**	

Appointment bookings via
www.qdst.com.au

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
Auchenflower: River City Private Hospital, Level 4 / 401 Milton Road, Q 4066
Greenslopes: Respiratory & Sleep Brisbane, 3 / 496 Logan Road, Q 4120
Southport: Pacific Private Clinic, Suite 3B, Level 4, 123 Nerang Street, Q 4215