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

Chermside: 4 / 738 Gympie Road, Q 4032

Greenslopes: Respiratory & Sleep Brisbane, 3 / 496 Logan Road, Q 4120

North Lakes: Lakes Medical Specialists, 4 / 12 Endeavour Blvd, Q 4509

Southport: Pacific Private Clinic, Suite 3B, Level 4, 123 Nerang Street, Q 4215