QLD DENTAL
SLEEP THERAPY

reception@qdst.com.au
07 3185 4910
www.qdst.com.au

REFERRAL FORM

PATIENT DETAILS

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

I AM REFERRING MY PATIENT FOR:

- ☐ Suspected sleep apnoea
- ☐ MAS therapy for snoring/OSA treatment
- ☐ Bruxism
- ☐ Growth focused Orthodontics
- ☐ TMJ concerns
- ☐ Breathing / Muscular Dysfunctions

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 3C, Level 4, 123 Nerang Street, Q 4215