SLEEP STUDY REFERRAL FORM
Matilda International Hospital
41 Mount Kellett Road, The Peak , Hong Kong

Please fax or email completed form to MS **Tel: 28491200** **Fax: 28492564**
Email: MSP@Matilda.org

PATIENT DETAIL

Name : _____ Sex: Male ☐ Female ☐

DOB : _____ Age : _____

ID/Passport Number : _____ Contact Number : _____

Email : _____ Past Medical History _____

REFERRING PHYSICIAN

Referring Physician _____ Perferred Reporting Physician: _____

PROCEDURE INFORMATION

Procedure Date: _____ Perferred Company: _____

Procedure Requirec □ Full Polysomnography
□ 6 Channel
□ CPAP Titration

REASON FOR REFERRAL

□ Snoring
☐ Sleep Apnea
☐ Insomnia
☐ Excessive Daytime Sleepiness
☐ Restless Legs Syndrome
☐ Periodic Limb Movements
☐ Rhythmic Movement Disorder
☐ Circadian Rhythm Disorder
☐ Mood Disorder
☐ Anxiety

□ Parasomnia
☐ Chronic Fatigue Syndrome
☐ Obesity (Bariatric Surgery)
☐ CPAP Titration
☐ CPAP Follow-Up
☐ Oral Appliance Assessment
☐ Treatment Follow-Up
☐ Other _____