

INTERIOR LUNG AND SLEEP CLINIC

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Referral date:

Patient details:

Name:

Address:

PHN:

DOB:

Phone number:

Lung Conditions	Sleep
<u>Airways disease</u> - COPD - Asthma - <i>Has patient had spirometry within the last year? Y ____ N ____</i> - Bronchiectasis	<u>OSA</u> <i>Please attach any sleep studies</i>
<u>Pulmonary Fibrosis</u> - <i>Has patient had full PFTs within the last year? Y ____ N ____</i> - <i>Has patient had a CT scan within the last year Y ____ N ____</i>	<u>Other</u> - Insomnia - RLS/PLMs - Narcolepsy/excess sleepiness - Parasomnia/nightmare disorder - Other _____
<u>Nodules/Malignancy</u> - <i>Is the largest nodule > 8 mm ?</i> Y N	
Other: _____	

Please attach medical profile and current medication list

Referring Provider: _____ MSP: _____

Signature: _____

Clinic Phone: _____

Clinic Fax: _____