INTERIOR LUNG AND SLEEP CLINIC

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Referral date:

Patient details:
Name:
Address:
PHN:
DOB:
Phone number:

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

Please attach medical profile and current medication list

Referring Provider: _____ MSP: _____

Signature: _____

Clinic Phone: _____

Clinic Fax: _____