Referral Letter

The New Clinic

PATIENT DETAILS

NAME:

DATE OF BIRTH:

PHONE NUMBER:

EMAIL:

CLINICAL INFORMATION (Please tick as appropriate)

- ☐ Snoring
- ☐ Nocturnal Gasping / Choking
- ☐ Witnessed Apnoea's
- ☐ Unrefreshing Sleep
- ☐ Daytime Lethargy / Sleepiness
- ☐ Insomnia
- ☐ PTSD
- ☐ Chronic Pain
- ☐ Mood or Anxiety Disorder with Insomnia
- ☐ Concentration Issues / Fatigue
- ☐ Stress
- ☐ Anxiety / Depression
- ☐ Hypertension / Cardiac History
- ☐ Sexual Disinterest
- ☐ Restless Legs
- ☐ Specialist Paediatric Consultation for CBD
- ☐ Other:

DOCTOR'S DETAILS

REFERRING DOCTOR:

PROVIDER NUMBER:

ADDRESS:

PRACTICE NAME:

PHONE NUMBER:

SIGNATURE:

DATE:

The New Clinic

Services are offered both in Clinic and via Telehealth video consults. Please send referral via fax or email and also give copy to Patient.

1300 375 384 **(02) 4302 0620** **hello@thenewclinic.com.au** **thenewclinic.com.au**