



Dr Mina Shehata

BMedSci, MD, FRACP

Sleep & Respiratory Specialist

PATIENT REFERRAL

Referring GP / Specialist

Referring Doctor: _____

Provider Number: _____

Practice / Clinic: _____

Phone/Email: _____ Fax: _____

Patient Details

Full Name: _____ Date of Birth: _____ M F Other

Address: _____

Phone: _____

Reason for Referral / Clinical Summary _____

Service Requested:

- Sleep Specialist Consultation
- Respiratory Specialist Consultation
- Home Sleep Study (*Medicare Eligible*)
- Other: _____

Medicare Eligibility (GP Initiated Home Sleep Study)

- STOP-Bang ≥ 3 + ESS ≥ 8
- OSA50 ≥ 5 + ESS ≥ 8
- STOP-Bang _____ OSA50 _____ ESS _____

Signature _____ Date _____

Consultations Available In

Sydney

My ENT Clinic

Ph (02) 9247 1762

Miranda

Shire Respiratory & Sleep

Ph (02) 9553 0006

