Service request to:
Email: referral@drbentleyinc.com

DR ALISON BENTLEY
MBBCh (Wits) PhD
Pr: 1493604

ABentley Inc
Contact: 011 463 0361
Consultation: 064 166 1710
Dr Bentley: 074 236 3087
WhatsApp: 068 534 1578

Request for Sleep Investigation / Management

Patient Information

Name & Surname _____ Contact No _____

ID No _____ Email _____

In Hospital only: Hospital Home Study Ward _____

Medical Aid

Medical Aid Name _____ Medical Aid Number _____

Medical Aid Plan _____ Medical Aid Dependant Code _____

Main Member _____ Main Member ID No _____

Reason For Request

Is this request related to the management of a PMB condition? Yes ☐ No ☐

If yes, please advise the condition _____

Arythmia ☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐

Services Required (specify services)

Sleep study and CPAP titration study (if applicable) report to be sent back to referring doctor and a copy sent to the patient.

Screening for sleep apnea: Home-Based ☐
(Please attach data sheet)

Screening for sleep apnea: Hospital-Based ☐
(Please attach copy of sleep apnea screen or full PSG if previously conducted)

CPAP Auto-Titration ☐

Consultation for Sleep Disorder ☐

Consultation for CPAP follow-up management plus 6 monthly CPAP compliance reports ☐

Please send copy of results to the following doctors:

_____

_____

Requesting Doctor

_____ Name and Surname

_____ Email address

_____ Practice Number

_____ Contact Number

_____ Date

_____ Signature