

SUTHERLAND HOSPITAL OUTPATIENT CLINICS

FAX TO: 9540 8067

PHONE ENQUIRIES: 9540 7067

REFERRAL DATE:

OUTPATIENT CLINIC SERVICE:

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| Diabetes <input type="checkbox"/> Dr Ganesh Chockalingam <input type="checkbox"/> Dr Malgorzata Brzozowska | Renal <input type="checkbox"/> Dr Parthasarathy Shanmugasundaram | Respiratory Failure <input type="checkbox"/> Dr Con Archis |
| Endocrine <input type="checkbox"/> Dr Ganesh Cockalingam <input type="checkbox"/> Dr Malgorzata Brzozowska | Renal Palliative Care <input type="checkbox"/> Dr Frank Brennan | Respiratory OPD <input type="checkbox"/> Dr Ben Kwan |
| Rehabilitation <input type="checkbox"/> Dr Lucy Ramon | Neurology <input type="checkbox"/> Dr Manisha Narasimham | Respiratory Assessment <input type="checkbox"/> Dr Chin Goh |
| | Neurology / Rehabilitation <input type="checkbox"/> Dr Manisha Narasimhan <input type="checkbox"/> Dr Lucy Ramon | Sleep Clinic <input type="checkbox"/> Dr Andrew Ng |

REASON FOR REFERRAL *(Mandatory For ALL Referrals)*

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| | TYPE OF DIABETES: <input type="checkbox"/> T1DM <input type="checkbox"/> T2DM <input type="checkbox"/> GDM |
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REFERRING DOCTOR

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| NAME: ADDRESS: | PROVIDER NO: PHONE: FAX: EMAIL: |
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PATIENT INFORMATION

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|--------------------------|-------------------------|
| NAME: | GENDER : |
| COUNTRY OF BIRTH: | DATE OF BIRTH: |
| ADDRESS: | HOME: |
| | WORK: |
| | MOBILE: |
| | EMAIL: |
| MEDICARE NUMBER: | PENSION NUMBER: |
| DVA NUMBER: | HEALTH INSURANCE |

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|----------------------------------------------------------|-----------------------------------------------------|
| TRANSLATOR REQUIREMENTS: <input type="checkbox"/> | LANGUAGE REQUIRED: |
| PATIENT CONSENT: <input type="checkbox"/> | ABORIGINAL or TSI : <input type="checkbox"/> |

CLINICAL INFORMATION

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| PAST MEDICAL HISTORY |
| ALLERGIES |
| CURRENT MEDICATIONS |
| INVESTIGATIONS |
| SOCIAL HISTORY |

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| SMOKING STATUS | ALCOHOL USE |
| EXERCISE <input type="checkbox"/> <60mins/wk <input type="checkbox"/> 100-150 mins/wk <input type="checkbox"/> >150mins/wk | DIET <input type="checkbox"/> Poor <input type="checkbox"/> Adequate <input type="checkbox"/> Good |

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|---------------------|-------------|
| GP SIGNATURE | DATE |
|---------------------|-------------|

