

Date of Referral:	Referring doctor details
Referral to:	Name :
Dr Stephen Philcox <input type="checkbox"/>	Contact # :
Dr Robert Gibson <input type="checkbox"/>	
Dr Lay Gan <input type="checkbox"/>	

Patient details	
Name	:
DOB	:
Address	:
Suburb	:
State	:
Contact #	:
Medicare #	:

Medical History Requiring Specialist Consultation		Medications Requiring Special Instructions	
AMI/CABG/Stent	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>
CCF	<input type="checkbox"/>	Clopidogrel or similar	<input type="checkbox"/>
AF	<input type="checkbox"/>	Warfarin	<input type="checkbox"/>
CVA/TIA	<input type="checkbox"/>	Dabigatran or rivaroxaban	<input type="checkbox"/>
COPD	<input type="checkbox"/>	NSAIDs	<input type="checkbox"/>
(Home oxygen Y/N)			
OSA	<input type="checkbox"/>	Allergies?	<input type="checkbox"/>
(CPAP Y/N)		Details:	
DM I/DM II (Please circle)	<input type="checkbox"/>		
Insulin requiring	<input type="checkbox"/>		
Oral hypoglycaemics	<input type="checkbox"/>		

Please direct any questions regarding this referral process to our reception on 02 4942 2111.
The design and suitability of the referral form will be reviewed based on your feedback.

