THE Lung Health CLINIC

REFERRAL FOR SPECIALIST CONSULTATION

REFERRING DOCTOR DETAILS / STAMP

* Required Field

CHOICE OF DOCTORS * ☐ Professor Philip Thompson ☐ Dr Rajesh Thomas ☐ Dr Weng Chin ☐ Mr Lucas Sanders

REFERRAL DURATION * ☐ 3 months ☐ 12 months ☐ Indefinite

PATIENT DETAILS

Name * _____ DOB * *dd/mm/yyyy* ___ / ___ / ____

ADDRESS

Street * _____

Suburb * _____ Post Code * _____

Telephone * *(mobile or home)* _____ Email _____

CLINICAL HISTORY/REASON FOR REFERRAL *

REFERRING DOCTOR/STAMP

Doctors Name * _____

Practice Name * _____ Provider Number * _____

ADDRESS

Street * _____

Suburb * _____ Post Code * _____

Telephone * _____

Email _____

Date of Request * ___ / ___ / ____ Signature * _____

PLEASE ALSO ATTACH ANY DOCUMENTS OR FILES WHICH MAY RELATE TO THIS REFERRAL

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