Northern
Specialist Suites

Referral Form

Referral to Doctor .....

Patient Name ..... Date ...../...../.....

Address .....

Date of Birth ..... Phone .....

Preferred Language ..... Interpreter required (Yes/No) .....

Please describe clinical particulars .....

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Please tick ✓ the required service(s)

Cardiology
- ○ Consultation
- ○ ECG
- ○ Echocardiogram
- ○ Holter
- ○ Exercise Stress Test
- ○ 24hr AMB Blood Pressure Monitoring

Respiratory/Sleep
- ○ Respiratory/Sleep Consultation
- ○ Spirometry
- ○ 6 Minute Walk Test
- ○ Sleep Study
- ○ Full Lung Function Test (inc. spirometry lung volumes & gas transfer)

- ○ Gynaecologist
- ○ Diabetes/Endocrine
- ○ General Surgery
- ○ General Physician
- ○ Orthopaedic Surgeon
- ○ Other

Referring Doctor .....

Medical Clinic .....

Address .....

Phone .....

Provider No. .....

Requesting Physician .....

Name .....

Address .....

Phone .....

Provider No. .....

For further enquiries, please call Northern Specialist Suites Phone 8250 0311 Fax 8250 0322
Level 1, HMH Towers, 42-48 Garden Tce, Mawson Lakes 5095 SA

Treated with *care* ♥