MEDALLIANCE

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Dr. Lindsay Chow (Gastroenterologist)
Dr. Justin Jackson (Infectious Disease)
Dr. John Burston (Infectious Disease)
Dr. Michael Kelly (Upper GI Surgery)
Dr. Wei Sim (Cardiologist)
Dr. Hecham Harb (Endocrinologist)
Dr. Elizabeth O'Brien (Gastroenterologist)
A/Prof. T. McKenzie and associates (Riverina Respiratory & Sleep Centre)

PATIENT REFERRAL

PATIENT DETAILS

Name: _____

Address: _____

Phone: _____

Mobile Phone: _____

Date of Birth: _____

Medicare No.: _____

REFERRER DETAIL

Name: _____

Practice: _____

Practice Address: _____

Phone: _____

Provider Number: _____

Date: *(dd/mm/yyyy)* _____

email: _____

CONSULTATION/INVESTIGATIONS REQUIRED

- ☐ Echocardiogram
- ☐ Stress Echocardiogram
- ☐ Holter Monitor
- ☐ Device Interrogation
- ☐ Gastroscopy
- ☐ Colonoscopy
- ☐ Capsule Endoscopy
- ☐ ERCP
- ☐ 24 Hour pH Study
- ☐ Oesophageal Manometry
- ☐ Consultation *(choose an item)*

REASON FOR REFERRAL

Please advise of any special circumstances; such as, fall risk from difficulty mobilising, inability to follow instructions from cognitive impairment, requiring monitoring, supplemental oxygen or nurse escort or multi-drug resistance organism infection.

Relevant Past Medical History: _____

Current Medications: _____

Allergies: _____

Relevant Investigation Reports: _____

Signature: _____

Referral Valid for: 12 Months