

Patient Referral Form

The Sutherland Hospital Outpatient Department
Cnr of Kingsway and Kareena Rd,
Caringbah NSW 2229

PHONE: 02 9540 7067

FAX: 02 9540 8067

EMAIL: SESLHD-TSH-Outpatients@health.nsw.gov.au

Referral to Dr *(one named clinician)*

Outpatient Clinic use only

Referral received:

Referrer notified of receipt:

Clinic/Doctors

Respiratory and Sleep

Dr Clarissa Susanto
Dr Adelle Jee
Dr Chin Goh
Dr Vicki Chang
Dr Con Archis
Dr Johnathan Man

Endocrinology

Dr Malgorzata Brzozowska
Dr Michael Bennett
Dr Ganesh Chockalingam
Dr Matthew Luttrell

Neurology

Dr Ik Lin Tan
Dr Manisha Narasimhan
Dr Benjamin Nham
Dr Rajiv Wijesinghe
Dr Sully Fuentes-Patarroyo
Dr Derrick Soh

Gynaecology PH-9540 7240

Dr Amani Harris
Dr Dean Conrad
Dr John Breen
Dr Chandra Krishnan

Infectious Diseases:

Dr Ben Knippenberg
Dr Roselle Robosa

Rehabilitation

Dr Lucy Ramon
Dr Eunice Lin

Paediatrics PH- 9540 7384

Dr Alys Swindlehurst
Dr Henry Gilbert
Dr James Tong
Dr Elizabeth Berger

Dermatology- 9540 8321

Dr John Sullivan

Patient Details

Patient Name:	
Title	
DOB	
Address	
Sex/Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X (indeterminate/intersex/unspecified)
Phone	
Email	
Compensable Status	<input type="checkbox"/> DVA <input type="checkbox"/> WorkCover <input type="checkbox"/> Motor Vehicle Third Party Insurance <input type="checkbox"/> Other
Identifies as Aboriginal or Torres Strait Islander origin	<input type="checkbox"/> YES <input type="checkbox"/> NO
Interpreter required	<input type="checkbox"/> YES <input type="checkbox"/> NO
Language
Medicare Number	

Clinical Details

Reason for Referral <i>(including presenting symptoms – onset, duration and severity, if appropriate – and physical findings)</i>	
Any previous treatment or investigations for referral condition	
Any previous surgery	
Any other co-existing conditions	
Any current medication (including any allergies)	

Referrer Details

Name		<input type="checkbox"/> GP <input type="checkbox"/> Other
Provider Number		
Phone		
Email		
Fax		
Signature		
Date		

Other details if required

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