Patient Referral Form

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

PHONE: 02 9540 8321

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

Referral to Dr *(one named clinician)*

Outpatient Clinic use only

Referral received:

Referrer notified of receipt:

Clinic/Doctors

Dermatology

Dr John Sullivan

Patient Details

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

Clinical Details

Reason for Referral *(including presenting symptoms – onset, duration and severity, if appropriate – and physical findings)*	
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		☐ GP ☐ Other
Provider Number		
Phone		
Email		
Fax		
Signature		
Date		

Other details if required