



**North Metropolitan Area Health Service**

**REQUEST FOR OUTPATIENT APPOINTMENT**

**MIDLAND PHYSICIAN SERVICE: SKHS EVELINE CENTRE CLINIC  
SWAN KALAMUNDA HEALTH SERVICE**

Re: .....  
*(Patient's Name)*

DOB: .....

Contact number: .....

**When completed please fax  
referral to: (08) 9347 5933**

**NAME OF SPECIALIST PREFERRED**

Only Named Consultant referrals are accepted. Please tick the box against your preferred Consultant. The preferred Consultant may assign a patient to be seen by his colleagues for a variety of reasons. (ie clinical urgency). You have the option of choosing more than one consultant/speciality. **Doing so will ensure that your patient will be seen by the first available consultant.**

✓	Specialist	Interests	✓	Specialist	Interests
	<b>General Medicine</b>			<b>Gastroenterology</b>	
	Dr Tim Bates	General , Lipid Disorders, Stroke, Diabetes,		Dr Glen Brand	Gastro Clinic Endoscopy
	Dr Glen Brand	All areas		Dr Nick Kontorinis	Gastro/Hepatology Endoscopy
	Dr Mark Lee	General Medicine, Diabetes		Dr Kannan Venugopal	Gastro Clinic Endoscopy
	Dr Jee Kong	General Medicine		Dr Jee Kong	Gastro Clinic Endoscopy
	Dr Siang Ung	General Medicine, Cardiology		<b>Cardiology</b>	
	<b>Infectious Diseases</b>			Dr Siang Ung	General Cardiology
	Dr Marilyn Hassell	Infections. Antibiotic therapy		Dr Vince Paul	Arrhythmias
	<b>Respiratory Medicine</b>			<b>Neurology</b>	
	Dr Helen Bell	General Respiratory		Dr Lay Kho	Neurology/Epilepsy
	Dr Ivan Ling	General Respiratory		<b>Endocrinology</b>	
	<b>Renal Medicine</b>			Dr Mark Lee	Diabetes
	Dr Doris Chan	CKD			

Referring Doctor's name: \_\_\_\_\_ Signature: \_\_\_\_\_

Medical Practice \_\_\_\_\_

Provider Number: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / 2012

Swan Kalamunda Health Service, Eveline Road, Middle Swan, Western Australia 6056 1  
Letters PO Box 195, Midland Western Australia 6936  
Telephone (08) 9347 5922 Facsimile (08) 9347 5933  
ABN: 13 993 250 709  
<http://www.health.wa.gov.au>





**North Metropolitan Area Health Service**

**REFERRAL LETTER**

**Consultant Name** \_\_\_\_\_

**Re:** \_\_\_\_\_  
*(Patient's Name)*

**Address:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Contact no:** \_\_\_\_\_

**REASON FOR REFERRING (please tick more than one if applicable)**

- Assessment Only
- Diagnostic Procedure
- Assessment and Management
- Suitable for Day Surgery
- Hospital to Share Management with GP
- Second Consultant Opinion

**Current Problem**

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**Past History.**

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**Current Medications.**

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**Allergies**

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**Other (e.g. Social, occupational, family)**

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**PLEASE ATTACH COPIES OF ANY RELEVANT INVESTIGATIONS / REPORTS / LETTERS**