



**Urgent**

## Medical Referral Form

Please fax your referral to (02)4252-7334 or email to [frontdesk@shsmedical.com.au](mailto:frontdesk@shsmedical.com.au)

**Specialist you are referring to:**

### General Information

Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_ D.O.B: \_\_\_\_\_

### Clinical notes / reason for referral

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Paediatric Services

- Paediatric Consultation       Sleep Study       Developmental Consultation

### Sleep Investigation

- Diagnostic Sleep Study       MSLT       Sleep Physician Consultation  
 CPAP Pressure Review Study       MWT       Ambulatory Oximetry

### Respiratory Investigation

- Spirometry       Skin Prick Test       Lung Volumes       Diffusing Capacity (DLCO/KCO)

### Neurology Investigation

- EEG - Routine       EEG - Prolonged       Paediatric EEG       Neurologist Consultation  
 Botox

### Referring Doctor Details

Stamp

Name: \_\_\_\_\_  
Provider Number: \_\_\_\_\_  
Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Provider number: \_\_\_\_\_

Date: \_\_\_\_\_

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