



Outpatient Department
St George Hospital
Ground Floor, Prince William Wing
T: 9113 2513 F: 9113 2297

TO:

Aged Care Clinic <input type="checkbox"/> Dr Baird <input type="checkbox"/> Dr Pickard <input type="checkbox"/> Dr Baldwin <input type="checkbox"/> Dr Xu <input type="checkbox"/> Dr Chuang <input type="checkbox"/> Dr Youssef <input type="checkbox"/> Dr Morfis	Colorectal Clinic <input type="checkbox"/> Prof Lubowski	Dermatology Clinic <input type="checkbox"/> Prof D Murrell	Diabetes Clinic <input type="checkbox"/> Prof Diamond <input type="checkbox"/> Dr Rohl <input type="checkbox"/> Prof O'Sullivan <input type="checkbox"/> Prof Smerdely <input type="checkbox"/> Dr Reyes (Transition and Young Adults)
Drug & Alcohol Clinic <input type="checkbox"/> Dr Gottlieb	Endocrine Clinic <input type="checkbox"/> Prof Diamond <input type="checkbox"/> Prof O'Sullivan <input type="checkbox"/> Prof Smerdely	Gastroenterology Clinic <input type="checkbox"/> Prof Grimm <input type="checkbox"/> Dr Paven <input type="checkbox"/> Dr Choo (Complete this form and Attachment GAS-V1)	Haematology Clinic <input type="checkbox"/> Prof Chong <input type="checkbox"/> Prof Lee <input type="checkbox"/> Dr Hugman <input type="checkbox"/> Dr Passam
Immunology <input type="checkbox"/> Prof Krillis	Infectious Disease Clinic <input type="checkbox"/> Dr Weatherall <input type="checkbox"/> Dr Konency	Neurology Clinic <input type="checkbox"/> Prof Hersch <input type="checkbox"/> Dr Allport <input type="checkbox"/> Dr Matar <input type="checkbox"/> Dr Prosser <input type="checkbox"/> Dr Justine Wang	Rheumatology Clinic <input type="checkbox"/> Dr Giannakopoulos
Swallow Clinic <input type="checkbox"/> Prof Cook	Vascular Clinic <input type="checkbox"/> Dr Farmer <input type="checkbox"/> Dr Iliopoulos <input type="checkbox"/> Dr Lemech	Wound Clinic <input type="checkbox"/> Wound CNC	

Only Clinicians listed are available within this Department.

PATIENT SURNAME: _____

FIRST NAME: _____

DOB: _____

MALE / FEMALE

- Non-Medicare
- Workers Comp
- DVA
- Medicare

ADDRESS: _____

Medicare No: _____

Telephone Contact Mobile: _____

Home: _____

INTERPRETER Required: Yes / No

Dialect: _____

CLINICAL INFORMATION: _____

Please attach any additional information or recent results.

DOCTOR'S SIGNATURE:

DATE:

Dr Requesting	
Provider No.	
Telephone & Fax	, Fax:
Address	

(Please complete this section in full or with practice stamp)

(Practice Stamp)