Macquarie Respiratory and Sleep

Referral to see a Respiratory and Sleep Physician

Date: ______________________________

Patient Name: ______________________________

DOB: ______________________________

Address: ______________________________

Contact number: ______________________________

Purpose of consultation:

- ☐ Asthma
- ☐ Sleep disorder
- ☐ Investigation of abnormal radiology
- ☐ Assessment of breathlessness
- ☐ COPD
- ☐ Cough
- ☐ Chest Infection
- ☐ Other ______________

Clinical information: ______________________________

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Referring doctor: ______________________________

Provider number: ______________________________

Address: ______________________________

Fax: ______________ Phone: ______________

Contact for appointments

Phone: 02 9812 3709 Fax: 02 9812 3844

Macquarie University Hospital Clinic

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