CAMDEN AND CAMPBELLTOWN HOSPITALS
ADULT OUTPATIENTS CLINIC REFERRAL FORM

Health
South Western Sydney
Local Health District

DATE: _____

Camden	Fax: 4654 6170	Phone: 4654 6174
Campbelltown		
Antenatal	Fax: 4634 4700	Phone: 4634 4963 (Option 1)
Specialist Clinics	Fax: 4634 4701	Phone: 4634 4963 (Option 2)

Please fax this request to the above number and a confirmation letter will be sent directly to the patient.

Affix Patient ID Label Here
(Hospital use only)

Campbelltown:

- ☐ **Antenatal / Gynaecology**
  - ☐ Dr R Dalal
  - ☐ Dr N Lambert
  - ☐ Dr M Reddy
  - ☐ Dr J Song
- ☐ **Sleep & Respiratory**
  - ☐ D K Chan
  - ☐ D E Meggitt
  - ☐ Dr N Haider
  - ☐ Dr C Santos
  - ☐ G Thompson
  - ☐ ***Respiratory Function Test***
- ☐ **Cardiology**
  - ☐ Dr A O'Loughlin
- ☐ **Neurology**
  - ☐ Dr H Choong
  - ☐ Dr S Gopinath
  - ☐ Dr S Levy
  - ☐ Dr V Patel
  - ☐ Dr L Rigney
  - ☐ ***EEG***
  - ☐ ***Nerve Conduction***
- ☐ **Endocrinology (Adult)**
  - ☐ Dr B Chan
  - ☐ Dr J Estrella
  - ☐ Dr K Ho
  - ☐ Dr I Kuo
  - ☐ Dr C Perera
  - ☐ Dr M Piya
  - ☐ Dr R Rajagopal
  - ☐ Prof D Simmons
  - ☐ Dr P Shan
- ☐ **Hypertension**
  - ☐ Prof A Hennessy
- ☐ **Gastroenterology**
  - ☐ Dr V Ho (Gastro)
  - ☐ Dr W C Teoh (Liver)
- ☐ **Immunology**
  - ☐ Dr B Frankum
  - ☐ Dr C Katelaris
  - ☐ Dr K Keat
  - ☐ D M Lee
- ☐ **Rheumatology**
  - ☐ Dr C El-Haddad
  - ☐ Prof K Pile

Camden:

- ☐ **Cardiology**
  - ☐ Dr A O'Loughlin
- ☐ **Hypertension**
  - ☐ Prof A Hennessy
- ☐ **Sleep & Respiratory**
  - ☐ Dr B Cochrane
  - ☐ Dr S Foo
  - ☐ Dr G Patel
- ☐ **Rheumatology**
  - ☐ Prof K Pile

Patient Name: …….. **Date of Birth:** ……..

Address: …… **Phone:** ……..

Medicare No: …… **Expiry:** ……..

Clinical Information: ……

……

……

……

……

Requesting Clinician: …….. **Provider Number:** ……

Address: …….. **Phone:** ……

Urgent referral: Yes / No

Please ensure <u>all</u> fields are completed and legible to enable us to process this referral