



**Fax or email referral to:**

- (08) 6371 5055
- [admin@midlandms.com.au](mailto:admin@midlandms.com.au)

**Patient Details - Attach patient label and include patient contact details**

Name: _____ DOB: _____ Gender: _____ Address: _____ Phone: _____ Mobile: _____ Medicare: _____ Reference: _____ Expiry: _____	<b>Patient Contact (Essential):</b>  Phone: _____ Mobile: _____  <b>Usual GP (if known):</b> _____
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**Select specialty as preferred specialist**  
If you only select the specialty, then the first available appointment with specialist in that field will be booked.

<input type="checkbox"/> <b>Renal Medicine</b> <input type="checkbox"/> Dr Siew Chong <input type="checkbox"/> Dr Kalindu Muthucumarana <input type="checkbox"/> Nurse Practitioner - Lenny Jacoby	<input type="checkbox"/> <b>Cardiology</b> <input type="checkbox"/> Dr Siang Ung <input type="checkbox"/> Dr Kalil Anvardeen <input type="checkbox"/> Dr Yuli Ten
<input type="checkbox"/> <b>Respiratory Medicine</b> <input type="checkbox"/> Dr Francesco Piccolo <input type="checkbox"/> Dr David Manners <input type="checkbox"/> Dr Pradeep Balakrishnan <input type="checkbox"/> Dr Sarbroop Dhillon <input type="checkbox"/> Dr Phoebe Brownell	<input type="checkbox"/> <b>Gastroenterology</b> <input type="checkbox"/> Dr Jee Kong <input type="checkbox"/> Dr Michael Lim <input type="checkbox"/> Dr Michael Ma <input type="checkbox"/> Dr Tee Ching Hun <input type="checkbox"/> Dr Abhey Singh <input type="checkbox"/> Dr Suresh Ponnusamy <input type="checkbox"/> Dr Jacob Ooi <input type="checkbox"/> Dr Hooi-Ling Si
<input type="checkbox"/> <b>Diabetes and Endocrinology</b> <input type="checkbox"/> Dr Mark Lee <input type="checkbox"/> Dr Chandrin Jayasundera <input type="checkbox"/> Dr Sukesh Chandran <input type="checkbox"/> Dr Sze Ling Wong - Endocrine Surgeon	<input type="checkbox"/> <b>ENT Specialist</b> <input type="checkbox"/> Dr Aaron Anoosh Esmali <input type="checkbox"/> <b>Infectious Disease</b> <input type="checkbox"/> Dr Ohide Otome <input type="checkbox"/> <b>Immunology &amp; Allergy</b> <input type="checkbox"/> Dr Zhi Xiang Leang

**Clinical Details**

**URGENT**

**Referrer Details** **Doctor Stamp**

Doctor (Specialist): _____ Specialist Provider Number: _____ Address: _____ _____ Phone: _____	<div style="border: 1px solid black; height: 100px; width: 100%;"></div> Signature: _____ Date: _____
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