

Medical Outpatients Department

Level 1 West Block, Nepean Hospital
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NBMLHD-Medicalreferrals@health.nsw.gov.au



Health
Nepean Blue Mountains
Local Health District

SECTION 1: Specialists available in this department:

Gastroenterology	<input type="checkbox"/> Prof Martin Weltman <input type="checkbox"/> Dr Jamshid Kalantar	<input type="checkbox"/> Dr Calvin Chan	<input type="checkbox"/> Dr Jeff Chang	<input type="checkbox"/> Dr Rahim Daneshjoo
Inflammatory Bowel Disease	<input type="checkbox"/> Dr Jeff Chang			
Fibro scan	<input type="checkbox"/> Prof Martin Weltman			
Liver High Risk	<input type="checkbox"/> Prof Martin Weltman	<input type="checkbox"/> Dr Jeff Chang		
Neurology	<input type="checkbox"/> Dr Salman Khan	<input type="checkbox"/> Dr Ashish Malkan	<input type="checkbox"/> Dr Manori Wijayeth (Epilepsy)	<input type="checkbox"/> Dr Jerome Ip
Respiratory testing	<input type="checkbox"/> Dr Monica Comsa			
Infectious Diseases	<input type="checkbox"/> Dr James Branley <input type="checkbox"/> Dr Zoe Jennings	<input type="checkbox"/> Dr Archana Sud	<input type="checkbox"/> Dr Jeremy Brown	<input type="checkbox"/> Dr Vidhiya Menon
Immunology	<input type="checkbox"/> Dr James Yun			
Endocrinology (Non- Diabetic related)	<input type="checkbox"/> Dr Eun Ja Kris Park	<input type="checkbox"/> Dr Matthew Luttrell		

ALL OUR SPECIALISTS BULK BILL DIRECTLY TO MEDICARE

SECTION 2: Registrar Clinic:

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|---|--|--|---|
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory Test |
| <input type="checkbox"/> Immunology | <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Infectious Diseases | |

Nurse Clinic: ☐ Liver

SECTION 3: Patient Details

Name: _____ Date of Birth: _____
Address: _____
Phone: _____ Previous Surname/s: _____
Medicare No.: _____ Parent/Carer Name: _____

SECTION 4: Clinical Information

Please specify presenting problem below or attach relevant medical history, pathology and scanning to this referral.

SECTION 5: Referring Doctor

Name/Provider Number: _____
Practice: _____
Date: ____ / ____ / ____ Signature: _____

SECTION 6: Triage *HOSPITAL USE ONLY*

Doctor: _____ clinic _____
For: ☐ Consultant ☐ Registrar/Resident
Category: ☐ 1 (30 days) ☐ 2 (<90 days) ☐ 3 (365 days) Appointment time: ☐ 15 mins ☐ 30 ☐ 45 mins
Additional Investigation: ☐ Informed Patient: ☐
Comments: _____
Sign: _____ Date: ____ / ____ / ____