Sleep and Settle Referral

Gold Coast PRIVATE HOSPITAL

All admissions will be appointed to the on-call Leading Steps Paediatrician

PATIENT DETAILS

NAME: .....

DOB: DD/MM/YYYY ☐ FEMALE ☐ MALE

ADDRESS: .....

PHONE: .....

MEDICARE NUMBER: ..... REF: ..... EXPIRY: .....

☐ Private ☐ Third Party ☐ Self-funded

Health Fund: ..... Membership No: .....

REASON FOR REFERRAL

☐ Baby not sleeping
☐ Baby irritable
☐ Feeding problems
☐ Parent request
☐ Other: .....

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MEDICAL HISTORY (or attach separately)

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Current medications.....

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Investigations to date.....

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Please provide further information you feel may be of assistance

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REFERRING DOCTOR

Name: .....

Address: .....

..... Phone: .....

Signature: ..... Date: DD/MM/YYYY

Please FAX this form to 07 55 300 660 or email it to gcppaeds@healthscope.com.au and we will contact you to organise an appointment.

Phone 07 55 300 819 for further information and preparation advice.

Gold Coast Private Hospital
14 Hill Street, Southport QLD 4215 | www.goldcoastprivate.com.au