GOLD COAST
LUNG & SLEEP

Referral Form

Please fill in the following information:

Patient Details	
Patient Name:	
Date of Birth: (D/M/Y)	Home Phone:
Email:	Mobile:
Address:	
Clinical History:	

☐ Respiratory (please ☒ tick)	☐ Sleep (please ☒ tick)
☐ Suspected lung cancer	☐ Snoring
☐ Pulmonary nodule	☐ Obstructive sleep apnoea
☐ Asthma	☐ Restless legs syndrome
☐ COPD	☐ Central sleep apnoea
☐ Bronchiectasis	☐ Other
☐ Cough	
☐ Pleural disease	Sleep Tests:
☐ Pulmonary Hypertension	Diagnostic sleep study already performed: Yes / No
☐ Other	CPAP study already performed: Yes / No

Referring Doctor Details	
Name:	Provider Number:
Practice Name:	Address:
Contact Number:	Date: (DD/MM/YYYY)
Notes:	

Consultation Address :

1. Suite 2, Level 5, 123 Nerang Street
Southport QLD 4215
Monday - 9 AM to 4 PM
Wednesday - 9 AM to 4 PM

2. Ultima Harbourside, Shop 6/29 Wharf St
Tweed Heads NSW 2485
Tuesday - 9 AM to 4 PM

For Appointments : - Phone No. : (07) 5619 7478 | Fax : (07) 5532 8307