

## Medical Outpatients Department

Level 1 West Block, Nepean Hospital  
Cnr Derby and Somerset St, Kingswood NSW 2747  
Ph: 4734 2352 (Option 1) Fax: 4734 2963 (Preferred)  
[NBMLHD-Medicalreferrals@health.nsw.gov.au](mailto: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:

<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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_