Specialist Referral

To
DR MD FIROZ IQBAL
BDS, MDSc (Syd Uni), MRACDS (Oral Med), FOMAA, FFOMP (RCPA)
Oral Medicine Specialist
Oral & Maxillofacial Pathologist

Consultation Room
5/149 Hawkesbury Road
Westmead NSW 2145
Tel: **02 9635 4900**

Patient Detail (In BLOCK LETTERS) **Referral Date**: _____/_____/_____

Title: _____ First Name: _____ Last Name: _____

D.O.B: _____/_____/_____ Gender: Male ☐ Female ☐

Language Spoken: English ☐ Other ☐ _____ Interpreter Required: Yes ☐ No ☐

Address: _____

_____ State NSW Postcode _____

Contact: Telephone _____ Mobile _____

Reason for Referral _____

_____

_____

_____

Significant Medical History (including allergies and medications) _____

_____

_____

Attachment Radiology: None ☐ Radiographs ☐ CT Scan ☐ MRI ☐ Ultrasound ☐

Blood test ☐ Biopsy report ☐ Other ☐ _____

Referring Practitioner Detail (In BLOCK LETTERS)

Full Name: _____ Signature _____

Practice Type: Dentist ☐ Medical Practitioner (GP) ☐ Specialist ☐ Provider # _____

Practice Address: _____

_____ State NSW Postcode _____

Contact: Telephone _____ Fax _____

E-mail: _____