Government of South Australia
SA Health

Southern Adelaide Local Health Network

NEUROLOGY OUTPATIENT CLINIC REQUEST FORM

(MR660)

Site: FLINDERS MEDICAL CENTRE (FMC)

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

Fax Referrals to: 08 8204 4059

Please tick one box below *(for Medicare billing purposes a named referral is required)*

☐ A.Prof D Schultz (HOU)	☐ MND Clinic (Fax 8204 6932)		☐ General Neurology
☐ Dr Lesley-Ann Hall	☐ MND Clinic (Fax 8204 6932)	☐ Multiple Sclerosis Clinic	☐ General Neurology
☐ A.Prof Mark Slee	☐ Multiple Sclerosis Clinic		
☐ Dr Joseph Frasca	☐ Epilepsy Clinic	☐ 1st Seizure Clinic (inc EEG)	☐ General Neurology
☐ Dr Emma Whitham	☐ Epilepsy Clinic	☐ 1st Seizure Clinic (inc EEG)	☐ General Neurology
☐ A.Prof Robert Wilcox	☐ Movement Disorder Clinic	☐ MD Genetics	☐ General Neurology
☐ Dr YiZhong Zhuang	☐ Movement Disorder Clinic		☐ General Neurology
☐ Dr Siew Lee Shu	☐ Movement Disorder Clinic		☐ General Neurology
☐ Dr Karyn Boundy	☐ Cognitive Disorder Clinic	☐ Huntington's Clinic	☐ General Neurology
☐ Dr Anthony Khoo	☐ Epilepsy Clinic		☐ General Neurology
☐ Dr James Triplett	☐ Neuromuscular Clinic		☐ General Neurology
☐ Dr Lavenia Cagi	☐ Neuromuscular Clinic		☐ General Neurology
☐ Registrar Clinic			☐ General Neurology

Patient Details

Patient's Clinical Notes: (Please attach any relevant clinical information, pathology results and data relating to this referral)

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☐ Ambulant ☐ Chair ☐ Bed

Family Name:

Given Name(s):

Address:

Date of birth: __ __ / __ __ / __ __ __ __

Gender: ☐ Male ☐ Female

Medicare No:

Home Phone:

Mobile:

Referral

Referring Doctor (please print)

.....

Please indicate treating consultant for referrals within FMC

Referring Doctor signature

Provider number:

Address:

.....

.....

FMC pager number:

Phone:

Fax:

Date: __ __ / __ __ / 2 0 __ __

Please use black ballpoint pen when completing this form

Form has dual purpose—Scan as
Referral **Out** –**Sending Referrer** Service
Referral **In** – (select Speciality) –**Receiving** Service/Clinic

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SALHN

April 2025