Referral fax: 02 9000 6621
Email: reception@luminamedical.com.au
Healthlink EDI: luminamg

Phone: 02 9000 6620

PAEDIATRIC EEG REFERRAL FORM

Has the patient or carer consented to Lumina receiving their personal information? **Yes** ☐ **No** ☐

REFERRING DOCTOR INFORMATION

First name
Last name
Provider #

Practice name
Practice address
Postcode
Practice phone
Practice fax

Healthlink ID

Doctor signature
Referral date

PATIENT INFORMATION

First name
Last name
Gender
Date of birth

Street address
Postcode
Phone
Email
Medicare #
(10 digits)
Individual #
(1 digit)
Expiry date

CLINICAL DETAILS

Referral to Doctor: Dr Ardern-Holmes ☐ Dr Gubara ☐

Reason for referral (please indicate relevant history, findings and investigations, and management, or attach summary):

THANK YOU FOR YOUR REFERRAL TO LUMINA

Lumina Kids' Brain & Mind Clinic,
Suite 1, 12-18 Tryon Road,
Lindfield, NSW 2070

e reception@luminamedical.com.au
t 02 9000 6620
www.luminamedical.com.au