Dr Sumit Yadav

MBBS MS MCh (C/Th) FRACS

Suite 4B, Level 2
Mater Medical Centre
21-37 Fulham Road
Pimlico, QLD 4812
T: 07 4775 5111
F: 07 4422 0009
E: info@sumityadav.com.au

Senior Clinical Lecturer
School of Medicine & Dentistry
James Cook University
Townsville, QLD 4814

Director Cardiothoracic Surgery
The Townsville Hospital
100 Angus Smith Drive,
Douglas QLD 4814
T:07 44331205
F:07 44331221

FRACS Fellow of the Royal Australasian College of Surgeons

REFERRAL FORM

Patient Details

Patient Name:_____ DOB:_____ Gender:_____

Address:_____ Suburb:_____ Postcode:_____

Home:_____ Mobile:_____

Email:_____

Referral Details

☐ URGENT ☐ Semi-urgent ☐ Standard

Referral Duration:_____ Referral Date:_____

Indications & Clinical Details

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Referring Doctor details

Name:_____ Provider Number:_____

Clinic:_____

Address:_____ Suburb:_____ Postcode:_____

Phone:_____ Fax:_____

Email:_____

Signature:_____ Date:_____