



Dr Brett Levin
Ear Nose & Throat Surgeon

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FRACS | AAFPS | ANZRS | AMA | ASOHNS

B Med Sci, MBBS (Hons), M Med Sci (Surg), FRACS (ORL-HNS)

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PATIENT REFERRAL

PATIENT DETAILS

NAME: _____

ADDRESS: _____

TEL: _____ DOB: _____

Insured Uninsured Work Cover DVA

REGIONS :

- | | | |
|--|---|--|
| <input type="checkbox"/> Paediatric ENT Assessment | <input type="checkbox"/> Sinusitis / Polyps | <input type="checkbox"/> Voice / Speech |
| <input type="checkbox"/> Snoring / OSA / CPAP Facilitation | <input type="checkbox"/> Epistaxis | <input type="checkbox"/> Hearing Loss / Tinnitus / Dizziness |
| <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Allergy | <input type="checkbox"/> Ear Clean / Blockage |
| <input type="checkbox"/> Neck / Parotid Lump | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Thyroid Lesion | <input type="checkbox"/> Acoustic Neuroma / Skull Base Lesion | <input type="checkbox"/> Cholesteatoma |

CLINICAL DETAILS

Could you please arrange appointment as:

Urgent ASAP Routine

REFERRING DOCTOR

DR : _____ PROVIDER NO : _____

ADDRESS : _____

SIGNATURE : _____ **DATE :** _____

Copy of Report to :
