



HAVAS ENT CLINICS

Excellence in otolaryngology

Patient Name: _____ DOB: _____

Address: _____

Postcode: _____

Medicare Number: _____

Bondi Junction Clinic North Sydney Clinic Kogarah Clinic

Clinical Notes:

Referring Details:

Doctor: _____

Address: _____

Postcode: _____

Phone: _____

Provider Number: _____

Date: _____

Signature: _____

- 3 month
- 12 Month
- Indefinite