

In accordance with Medicare Australia guidelines, a referral to one of our Pathologists is required for the performance of this test.

Patient Name	_____	Date of Birth	_____
Address	_____	Phone Home	_____
	_____	Work	_____
	_____	Mobile	_____

Thank you for seeing the above patient and performing a Synacthen Stimulation test.

Referring Doctor	_____		
Provider Number	_____		
Address	_____	Signature	_____
Phone	_____		
Fax		Date	_____

Please hand this form and a completed Sullivan Nicolaides Pathology request form to the patient