Referral Form - Lipid Clinic
FAX TO: 8738 4650

DEPARTMENT OF clinical genetics
LIVERPOOL HEALTH SERVICES

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MRN:
SURNAME:
GIVEN NAMES:
ADDRESS:
DOB:
PHONE:

AFFIX LABEL HERE

Date Referred : __ / __ / ____

Patient Contact No : _____

Interpreter Required? *(circle)* YES / NO

Language: _____

Relevant History:

Doctor's Signature: .....

Print Name: .....

Provider No.: .....

Phone No.: .....

Fax No.: .....

Reason for Referral:

Please attach hard copies of:

- **Current medication list**
- **Blood test results including :**
  - **Most recent Lipid profile**
  - **HbA1C**
  - **CK**
- **Cardiac imaging / interventions / procedure reports**

NB: Please note that referrals received MUST include referring doctor's name and provider number to be valid