

**DR PETER WU**  
M.B., B.S. (HONS), B.Sc (MED), F.R.A.C.P.  
**RESPIRATORY & SLEEP DISORDERS SPECIALIST**

Suite 103  
Specialist Medical Centre  
151 – 155 Hawkesbury Road  
Westmead 2145

Provider No.: 243360DB  
Tel: (02) 9633 2337  
Fax: (02) 9687 6321  
www.drpeterjcwu.com.au

### **Patient Details**

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Daytime Contact Number/s \_\_\_\_\_

### **Services Required**

- |   |  |
|---|--|
| <input type="checkbox"/> Respiratory consultation   | <input type="checkbox"/> Pre-operative assessment        |
| <input type="checkbox"/> Suspected lung cancer  | <input type="checkbox"/> Pulmonary arterial hypertension |
| <input type="checkbox"/> Interventional bronchology<br>(inc bronchoscopy, EBUS-TBNA,<br>stenting, laser bronchoscopy) | <input type="checkbox"/> Sleep disorders consultation    |
|   | <input type="checkbox"/> <b>Home sleep study</b>         |

### **Brief History**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Referring Doctor's Details**

Name \_\_\_\_\_ Date \_\_\_\_\_

Email \_\_\_\_\_ Provider Number \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

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