SELF REFERRAL

BY APPOINTMENT ONLY

Date: ___/___/___

Name: _____

Date of Birth: __/__/____

Male / Female / Other

Parent/Carer: _____

Mobile: _____

Email: _____

Medical History:

Asthma: YES / NO / UNSURE

COPD (Emphysema): YES / NO / UNSURE

Hay fever: YES / NO / UNSURE

Allergies: YES / NO / UNSURE

-if yes, allergic to: _____

Heart Condition: YES / NO / UNSURE

High Blood Pressure: YES / NO / UNSURE

TB (Tuberculosis): YES / NO

Other: _____

_____

Do you take medications: YES / NO

Please List Current Medication:

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Do you have a current doctor/medical clinic: YES/NO

Doctors name: _____

Clinic Name: _____

Other Info: _____

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Asthma Foundation Northern Territory

3 Nylander Street,
Parap NT 0820

P: 08 8981 6066
F: 08 8981 9066

E: asthmant@asthmant.org.au
www.asthmant.org.au

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