



Family & Community Services

Thank you for contacting Developmental Medicine Consulting for a specialist paediatric opinion regarding this child.

Child's name _____

Your name _____

Your role / title _____

FACS office _____

- I am aware of the fees for this child for the initial two consultations.
- I authorise payment for these, and have the delegation to do so.
- I understand payment is required on the day of the consultation.
- I understand that it is the Department's responsibility to provide Medicare numbers for this child, and their carer. If these numbers are not provided, I understand it is our responsibility to pay the full fees for these consultations.

Signed _____

Date _____

Please complete this page and either email, post or fax it back to us so that we can finalise this child's medical appointments. Please also complete the FACS Questionnaire, and bring it with the child's initial appointment.

Developmental Medicine Consulting

Thank you

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