



Referral letter

Visit date:

Client personal details

Family name: **JOY**
Given names: **PAUL**
Gender: **MALE**
Date of birth: **16 Jul 1993**
Country of birth: **INDIA**

Client identity details

Identity document presented: **Original Passport**
Identity document number: **M9362631**
Issuing country: **INDIA**
Date of issue: **15 Jul 2015**
Date of expiry: **14 Jul 2025**
Source: **Australia**

Client visa details

Visa: **573 Higher Education Sector (Temporary)**

Instructions to the client

Please proceed to make an appointment to undergo the required immigration health examinations listed in this letter with an approved panel physician if you are outside Australia **or** the Department of Immigration and Border Protection (DIBP)'s migration medical service provider if you are in Australia. You may also subsequently be referred to a specialist for additional health examinations. Specific requirements for arranging your health examination are explained on DIBP's website at <http://www.border.gov.au/Trav/Visa/Heal/Meeting-the-health-requirement/Arranging-a-health-examination>.

When making your appointment, please provide the clinic with your health identifying number (HAP ID) indicated at the top of this letter. Please also make sure that you bring with you to your appointment:

- **this referral letter**
- your prescription spectacles or contact lenses, if applicable
- existing specialist and/or other relevant medical reports for known medical conditions
- any previous chest x-rays
- a valid passport **OR** an agreed form of alternative documentation to confirm your identity.

Note: a copy of any health information that you have already provided to DIBP online is included below for your information. This information will also assist staff at the panel clinic that you select to visit.

Health Case Status

This health case has not yet been submitted to DIBP. The status of the individual examinations is listed below.

Examinations required for this visa application

| Exam | Status | Clinic |
|-----------------------------|----------|--------|
| 502 Chest X-ray Examination | Required | |
| 501 Medical Examination | Required | |

Referral letter

Consent provided

On 23 DEC 2015 you consented online to using eMedical to process your health examinations where available.

Medical History

History or informed of

| | |
|--|----|
| Tuberculosis (TB), treatment for tuberculosis? | No |
| Close household contact with Tuberculosis (TB)? | No |
| Prolonged medical treatment and/or repeated hospital admissions for any reason, including a major operation or psychiatric illness | No |
| Psychological/Psychiatric Disorder (including major depression, bipolar disorder or schizophrenia) | No |
| An abnormal or reactive HIV blood test | No |
| An abnormal or reactive Hepatitis B or hepatitis C blood test? | No |
| Cancer or Malignancy in the last 5 years | No |
| Diabetes | No |
| Heart condition including coronary disease, hypertension, valve or congenital disease | No |
| Blood condition (including thalassemia) | No |
| Kidney or Bladder Disease | No |
| An ongoing physical or intellectual disability affecting your current or future ability to function independently or be able to work full-time (including autism or developmental delay) | No |
| An addiction to drugs or alcohol | No |
| Are you taking any prescribed pills or medication (excluding oral contraceptives, over-the-counter medication and natural supplements)? Please list | No |

Client declaration

The client has provided true and correct medical history information.

Doctor declaration

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