

MATER URODYNAMIC CENTRE

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North Sydney NSW 2060
Phone: 9950 4610

SURNAME FIRST NAME

AGE

REFERRING DOCTOR

DATE / /

MAIN SYMPTOM(S)

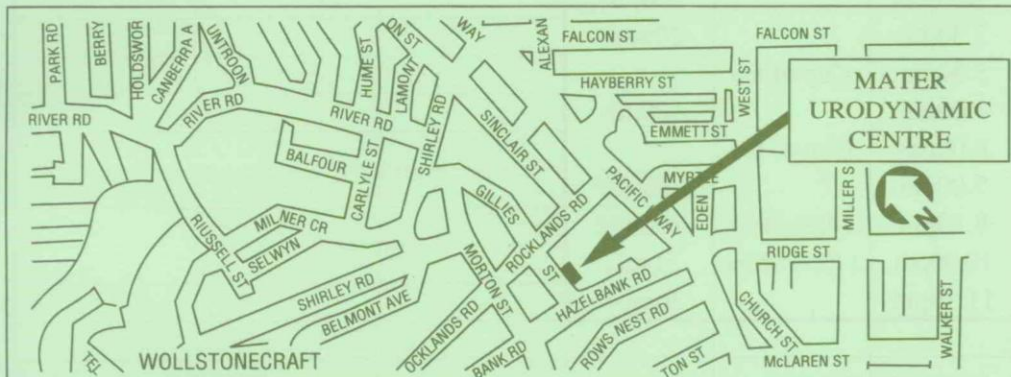
CLINICAL NOTES

REQUEST URODYNAMICS including TRANSVAGINAL ULTRASOUND

OTHER: Please specify

APPOINTMENT

DATE TIME



INSTRUCTIONS FOR PATIENTS

1. Kindly fill in the Chart overleaf during any 3 days in the week prior to your appointment and bring this sheet with you to the Clinic.
2. Try not to empty your bladder in the hour prior to your appointment.