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| Western Health General practice referral **Adult Specialist Clinics** **Ph 8345 6490 Fax 8345 6856****Women’s Clinic****(maternity and gynae)** **Ph 8345 1727 Fax 8345 1691****Paediatric Specialist Clinics** **Ph 83451616 Fax 8345 1079** |  | **Patient**Name:      Date of Birth: dd/mm/yyyy    /    /    Sex:      Referral date:dd/mm/yyyy    /    /     |

Please refer to Melbourne HealthPathways at[**http://melbourne.healthpathways.org.au**](http://melbourne.healthpathways.org.au)for guidance in assessing, managing and referring for patient conditions.

Referrals that do not include adequate information for triaging, including the **required minimum investigations** as per the HealthPathways and [www.westernhealth.org.au](http://www.wh.org.au/) will be returned with a request for further information.

**Western Health General practice referral**

Patient details

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| Name: Preferred name/s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:    /    /     Sex: Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:       Phone:       Work:       Mobile:       Email      Alternative contact:       Indigenous status:        |

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| Interpreter required:       Preferred language:       Pension card number:        |  | DVA number:       Insurance:       Medicare number:        |

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| Referring General Practitioner:Name:       ­­­­­­­­­­ \_\_Address:       \_\_Phone:       Fax:       Email:       Provider number:        |

Specialist Clinic requested

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Referral duration

 12 months Indefinite referrals (recommended for ongoing chronic conditions)

Reason for patient referral

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| **Referring doctor** | **Patient name:** | **Date:** dd/mm/yyyy    /    /     | Page 1 of 2 |
| Western Health General practice referral **Adult Specialist Clinics** **Ph 8345 6490 Fax 8345 6856****Women’s Clinic****(maternity and gynae)** **Ph 8345 1727 Fax 8345 1691****Paediatric Specialist Clinics** **Ph 83451616 Fax 8345 1079** |  | Patient**General practice referral**Name:      Date of Birth: dd/mm/yyyy    /    /    Sex:      UR Number:      Referral date:dd/mm/yyyy    /    /     |

Clinical information

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| **Medical past history:**       |

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| **Please attach relevant investigations. Name of pathology provider** |

**Current medications:**

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**Warnings:**

**Allergies:**

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| **Social history** |

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| **Referring doctor** | **Patient name:** | **Date:** dd/mm/yyyy    /    /     | Page 2 of 2 |