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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 |