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** 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 will be returned with a request for further information.

Patient details

Name: Preferred name/s:

Date of Birth: / / Sex: Title:

Address:

Phone: Work: Mobile:

Email Alternative contact: Indigenous status:

Interpreter required: DVA number:

Preferred language: Insurance:

Pension card number: Medicare number:

Referring General Practitioner:

Name:

Address:

Phone:

Fax:

Email:

Provider number:

Specialist Clinic requested

Referral duration

☐ 12 months ☐ Indefinite referrals (recommended for ongoing chronic conditions)

Reason for patient referral

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Clinical information

Medical past history:

Please attach relevant investigations. Name of pathology provider

Current medications:

Warnings:

Allergies:

Social history