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| Western Health General practice referral **Adult Specialist Clinics** **Ph 8345 6490 Fax 8345 6856****Women’s Clinic****(maternity and gynae) AND** **Paediatric Specialist Clinics** **Ph 8345 1727 Fax 9055 2125** |  | **Patient**Name:      Date of Birth:    /    /    Sex:      UR Number:      Referral date:   /    /     |

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 the required 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred name/s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ Date of Birth:    /    /     Address:       Sex: Phone:       Aboriginal [ ] Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Torres Strait Islander [ ] Mobile:       Both Aboriginal and Torres Strait Islander [ ]  Not Aboriginal or Torres Strait Islander [ ] Alternative contact:       No answer [ ]   |

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

Referring General Practitioner

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| Name:       ­­­­­­­­­­ \_\_Address:       \_\_Phone:       Fax:       Provider number:        |

Specialist Clinic requested

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Reason for Patient Referral (please clearly specify reason for referral)

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| **Referring doctor** | **Patient name:** | **Date:**    /    /     | Page 1 of 2 |
| Western Health General practice referral **Adult Specialist Clinics** **Ph 8345 6490 Fax 8345 6856****Women’s Clinic****(maternity and gynae) AND Paediatric Specialist Clinics** **Ph 8345 1727 Fax 9055 2125** |  | **Patient****General practice referral**Name:      Date of Birth:    /    /    Sex:      UR Number:      Referral date:   /    /     |

Clinical information (please attach relevant investigations and name of pathology provider)

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| **Medical past history:**  |

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| **Current medications:** |

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| **Warnings:** |

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| **Allergies:** |

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| **Social history:** |

Referral duration

 12 months Indefinite referrals (recommended for ongoing chronic conditions)

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