

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> 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 will be returned with a request for further information.

Patient details

Name: _____	Title: _____
Preferred name/s: _____	Date of Birth: / /
Address: _____	Sex: _____
Phone: _____	Aboriginal <input type="checkbox"/>
Work: _____	Torres Strait Islander <input type="checkbox"/>
Mobile: _____	Both Aboriginal and Torres Strait Islander <input type="checkbox"/>
Alternative contact: _____	Not Aboriginal or Torres Strait Islander <input type="checkbox"/>
	No answer <input type="checkbox"/>

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

Referring General Practitioner

Name: _____
Address: _____
Phone: _____
Fax: _____
Provider number: _____

Specialist Clinic requested

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

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

Medical past history:

Current medications:

Warnings:

Allergies:

Social history:

Referral duration

12 months Indefinite referrals (recommended for ongoing chronic conditions)

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