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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.

Patient details

**Western Health General practice referral**

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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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Clinic Head of Unit name:

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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 |