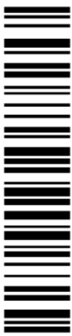

Western Health

Aboriginal & Torres Strait Islander Outpatient Clinic Referral Form

External Referral

Please complete form digitally and send as attachment to:
AboriginalAndTorresStraitIslanderClinic@wh.org.au

Please complete form digitally and send as attachment
Hospital UR: Click here to enter text.
Name: Click here to enter text.
Address: Click here to enter text.
Suburb and post code: Click here to enter text.
Telephone: Click here to enter text.
DOB: Click here to enter text.
Marital Status: Choose an item.
Gender: Choose an item.

Triage Use Only **Referral date** Click here to enter a date. **Triaged by:** Choose an item. Click here to enter a date.
Diagnosis/Main health condition: Click here to enter text. **Other factors Affecting Health:** Click here to enter text.

Referrers Name: Click here to enter text. **Position:** Click here to enter text. **Tel:** Click here to enter text.
Referrers Email Address: Click here to enter text.
Referring Hospital / Agency / Clinic: Click here to enter text.

GP Name: Click here to enter text. **Clinic Name:** Click here to enter text. **Address:** Click here to enter text.
Tel: Click here to enter text. **Fax:** Click here to enter text.

Contact Person/Next of Kin: Click here to enter text.
Tel: Click here to enter text.
Mobile: Click here to enter text.
Address: Click here to enter text.

NOK Relationship
Female NOK: Choose an item. **Male NOK:** Choose an item.
Contact Person for Appointments: Choose an item.

Case Manager (if Relevant): Click here to enter text. **Tel:** Click here to enter text.
Agency/Company Name: Click here to enter text.

Interpreter Required ☐ Yes ☐ No **Language:** Click here to enter text.

Patient or carer/NOK must consent to referral
Has the patient consented to this referral: ☐Yes ☐No

Must identify as Aboriginal and/or Torres Strait Islander and over 18 years of age

Please note- we cannot accept patients with acute surgical conditions
Patient requires 1 or more services from:

Service		Service	
Cardiology/Heart Failure Service	☐	Endocrinology	☐
Nephrology	☐	General Medicine	☐
Respiratory	☐		

Reason for Referral:
Click here to enter text.

Relevant Medical/Surgical History:
Click here to enter text.
Please attach current medication list ☐

Social History:
Click here to enter text.

Please attach recent relevant clinical investigation results (please tick all that apply)
☐Blood test ☐ X-ray ☐ Wound swab/biopsy ☐ Angiogram ☐ Holter Monitor ☐Echo ☐ MRI ☐ Bone scan
☐ Other (state): Click here to enter text.

Any special requirements:
Mobility issues ☐ Cognitive issues ☐ Bariatric ☐ Hearing/Visual Deficit ☐
Other- please describe in detail: Click here to enter text.

Carer Availability	**Carer Relationship**	**Living Arrangements**	**Accommodation**
☐No Carer	☐Spouse/Partner	☐Lives alone	☐Private (own/rent/purchased)
☐Co-resident carer	☐Parent	☐Lives with family	☐Outreach
☐Non-resident carer	☐Child	☐Lives with others	☐Supported Community
	☐Child in law	☐Not stated	☐Residential Aged Care
	☐Other relative		☐Residential Care facility (not aged)
	☐Friend/Neighbor		☐Short term Crisis/Emergency
	☐Foster Carer		☐Other accommodation

Country of Birth: Click here to enter text. **Aboriginal or Torres Strait Islander:** Choose an item.
Medicare Number: Click here to enter text. **Pension Number:** Click here to enter text. **DVA Number (if applicable):** Click here to enter text.
TAC? ☐ No ☐ Yes- **Claim Number:** Click here to enter text. **WorkCover?** ☐ No ☐ Yes- **Claim Number:** Click here to enter text.

Clerical use only **Requested appointment date:** Click here to enter a date. **Time:** Choose an item.
Booked on iPM: Click here to enter a date. **Time:** Choose an item. **Clerked by:** Click here to enter text.