**SPECIALIST CLINICS REFERRAL FORM**

**(From Health Service or Specialist)**

Telephone: (03) 9496 2900 Fax: (03) 9496 2097

**NOTE: Fields Marked with \*\* are mandatory**

|  |  |
| --- | --- |
| REFERRAL SOURCE:\*\*Health Service:Address:\*\*Referring Clinician Name:\*\*Provider No:Signature:  | CLIENT DETAILS:\*\*Name: \*\*Address:Male/Female\*\*Phone: Mobile: \*\*Date of Birth:Medicare No: Email:  |
| \*\*DATE OF REFERRAL: |
| CLIENT GP DETAILS:\*\*GP Name:\*\*GP Clinic:GP Clinic Address: |

|  |
| --- |
| \*\*UNIT REQUIRED:  |

|  |
| --- |
| \*\*REASON FOR REFERRAL: |

|  |
| --- |
| \*\*REFERRAL VALID FOR:  3 months   12 months |

|  |  |  |  |
| --- | --- | --- | --- |
| CLIENT INFORMATION: |  |  |  |
| Is the patient Aboriginal? | Yes or No | Is the patient a veteran? | Yes or No |
| Is the patient Torres Strait Islander? | Yes or No | DVA No:  |
| Has the patient attended this hospital? | Yes or No | Transport required? | Yes or No |
| Austin UR:  |  | Interpreter required?If Yes: which language: | Yes or No |

|  |
| --- |
| CLINICAL URGENCY: Urgent or Routine |

|  |  |  |
| --- | --- | --- |
| CURRENT MEDICATIONS:Attached: Yes or No | RECENT INVESTIGATION RESULTS:Attached: Yes or No | PAST HISTORY:Attached: Yes or No |

|  |  |
| --- | --- |
| SOCIAL FACTORS IMPACTING CARE:  |  |
| Will patient be arriving by ambulance? | Yes or No |
| Does person live alone? | Yes or No |
| Does the person have caring responsibilities for others? | Yes or No |
| Has the person been receiving community support services? | Yes or No |
| Please indicate if the patient may require assistance from the below services: |
| Dietician: Yes or No | Physiotherapy: Yes or No | Social Work: Yes or No | O.T: Yes or No |
| Other: |