**SPECIALIST CLINICS REFERRAL FORM**

**(From Health Service or Specialist)**

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

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

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| 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: | |

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| \*\*UNIT REQUIRED: |

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| \*\*REASON FOR REFERRAL: |

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

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| 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 | |

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| CLINICAL URGENCY: Urgent or Routine |

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

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| 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: | | | | |