|  |  |
| --- | --- |
| https://intranet.mercyhealth.com.au/about-us/PublishingImages/HighRes_Mercy%20Health_Full%20Colour%20Logo.jpg | **Werribee Mercy Hospital Outpatient Clinics Referral Form** |
| To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 300 Princes Highway, Werribee Vic 3030 | **Phone:** 03 8754 6700 **Fax:** 038754 6710 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details**  | **Previous WMH patient?** |[ ]  **Yes** |[ ]  **No** |
| **Full Name:**  |  | **ATSI - Self:** |  |
| **Date of Birth:** |  | **ATSI - Spouse:**  |  |
| **Address:** |  | **Eligible for Medicare?**  |[ ]  **Yes** |[ ]  **No** |
| **Suburb:** |  | **Post Code:** |  | **Medicare No:** |  | **IRN:** |  | **Exp. Date:** |  |
| **Phone (H):** |  | **Health Insurance Fund:** |  |
| **Mobile:** |  | **Health Insurance No.:** |  |
| **Interpreter Required?**  |[ ]  **Yes** |[ ]  **No** | **Disability or special needs:**  |[ ]  **Yes** |[ ]  **No** |
| **Language:**  |  | **Specify**: |  |

**Referring Doctor**

|  |  |
| --- | --- |
| **Print name: Designation:** | **Provider no.:**  |
| **Practice Name & Address:** |
| **Postcode:** |  | **Phone:** |  | **Fax:** |  |

**Patient Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Height (cm):** | Click here to enter text. | **Weight (kg):** | Click here to enter text. | **BMI:** | *Click here to enter text.* |

**Reason for Referral / Diagnosis**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

**Relevant co-morbidities / past medical/surgical/ mental health / genetic / family history:**

|  |
| --- |
|  |
|  |
|  |
|  |

**Medicines & Allergies:**

|  |
| --- |
|  |
|  |
|  |

**Investigations Ordered: (Please attach all relevant results to assist us to triage correctly)**

|  |
| --- |
|  |
|  |
|  |
|  |

**Doctor’s signature: Date:**

**You should receive written notification from us within 8 working days confirming receipt of your referral. Failure to supply all the required information may lead to a delay in your referral being processed as we may need to seek the additional information.**

**Pages to follow (including cover sheet):**

**IMPORTANT NOTICE – PRIVILEGED AND CONFIDENTIAL MESSAGE**

This facsimile transmission is intended for the exclusive use of the person or hospital to which it is addressed and may contain information that by law is privileged or confidential. If the reader of the facsimile transmission is not the intended recipient, you are hereby notified that any disclosure, distribution of copying of this transmission is prohibited by law, and the contents must be kept strictly confidential. If you have received this transmission in error, kindly notify us immediately and return the original to us at the above address.