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| https://intranet.mercyhealth.com.au/about-us/PublishingImages/HighRes_Mercy%20Health_Full%20Colour%20Logo.jpg | **Lymphoedema Clinic Referral Form** | |
| Mercy Public Hospital Inc- Mercy Hospital for Women (MHW) | |
| 163 Studley Road, Heidelberg Vic 3084 | **Phone: MHW** 03 8458 4949 **Fax**: 03 8458 4205 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Patient Details** | | | | | | | | **Previous MHW patient?** | | | | | | | | | | | | | | | |  | | **Yes** | | | |  | **No** |
| **Full Name:** | | Click here to enter text. | | | | | | | **ATSI - Self:** | | | | Choose an item. | | | | | | | | | | | | | | | | | | | |
| **Date of Birth:** | | Click here to enter text. | | | | | | | **ATSI - Spouse:** | | | | Choose an item. | | | | | | | | | | | | | | | | | | | |
| **Address:** | | Click here to enter text. | | | | | | | **Eligible for Medicare?** | | | | |  | | **Yes** | | | |  | | | | **No** | | | | | | | | |
| **Suburb:** | | Click here to enter text. | | | **Post Code:** | | | Click here to enter text.  **4**  **4** | **Medicare No:** | | Click here to enter text. | | | | | | **IRN** | | | | Ch | | | | | **Exp. Date:** | | | | Mm/yyyy | | |
| **Phone (H):** | | Click here to enter text. | | | | | | | **Health Insurance Fund:** | | | | | | Click here to enter text. | | | | | | | | | | | | | | | | | |
| **Mobile:** | | Click here to enter text. | | | | | | | **Health Insurance No.:** | | | | | | Click here to enter text. | | | | | | | | | | | | | | | | | |
| **Interpreter Required?** | | |  | **Yes** | |  | **No** | | **Disability or special needs:** | | | | | | | | | |  | | | | **Yes** | | | | |  | **No** | | | |
| **Language:** | | Click here to enter text. | | | | | | | **Specify**: | Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | **Carer Required?** | | |  | | Yes | | | |  | | | | No | | | | | | | | | | |

**Referring Doctor**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Print name:** | | Click here to enter text. | | | | **Provider no.:** | | | Click here to enter text. |
| **Practice Name & Address:** | | | Click here to enter text. | | | | | | |
| **Postcode:** | Click here to enter text. | | | **Phone:** | Click here to enter text. | | **Fax :** | Click here to enter text. | |

**Reason for Referral / Diagnosis**

|  |
| --- |
| Click here to enter text. |

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

|  |
| --- |
| Click here to enter text. |

**Medicines & Allergies:**

|  |
| --- |
| Click here to enter text. |

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

|  |
| --- |
| Click here to enter text. |

**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):**

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