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| https://intranet.mercyhealth.com.au/about-us/PublishingImages/HighRes_Mercy%20Health_Full%20Colour%20Logo.jpg | **Perineal MBS Clinic Referral Form** |
| Mercy Public Hospital Inc- Mercy Hospital for Women |
| 163 Studley Road, Heidelberg Vic 3084 | **Phone:** 03 8458 4500 **Fax:** 038458 4878 |

|  |  |  |  |
| --- | --- | --- | --- |
| **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. |

**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. |

**Period of Referral**

|  |  |  |
| --- | --- | --- |
| **Period of Referral:** |[ ]  3 months |[ ]  12 months |

**Referral to: \* Please select all boxes**

|  |  |
| --- | --- |
| **Urogynaecologist** | **Colorectal Surgeon** |
|[ ]  **Dr Lore Schierlitz** |[ ]  **Dr Alex Wong** |
|[ ]  **Dr Alison De Souza** |[ ]   |

|  |  |
| --- | --- |
| **Date of Perineal injury (date of baby’s birth)** | Click here to enter baby’s DOB |

**Current Symptoms**

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

**Past History: obstetric, medical, mental health, genetic, family**

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

**Medicines & Allergies:**

|  |
| --- |
| Click here to enter text. |
| 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: Designation \_\_\_\_\_\_\_ 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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