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| https://intranet.mercyhealth.com.au/about-us/PublishingImages/HighRes_Mercy%20Health_Full%20Colour%20Logo.jpg | **Urogynaecology Clinic Referral Form** |
| Mercy Public Hospital Inc- Mercy Hospital for Women |
| 163 Studley Road, Heidelberg Vic 3084 | **Phone:** 03 8458 4500 **Fax:** 038458 4205 |

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| --- | --- | --- | --- |
| **Patient Details**  | **Previous MHW 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:** |

**Period of Referral**

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

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| **Height (cm):** |  | **Weight (kg):** |  | **BMI:** |  |
| **Last PAP test ( *date & result*):** |  |  |  |  |  |  |

**Reason for Referral / Diagnosis:**

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**Relevant co-morbidities: obstetric, medical, surgical mental health, genetic, family:**

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**Medicines & Allergies:**

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

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**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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