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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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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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