Werribee Mercy Hospital Outpatients Referral		**Referral Date:** / / **GP Review Date:** / / **Feedback Requested:** ☐ Yes ☐ No

Outpatient contact details

Fax number for all referrals: 8754 6710	**Outpatient enquires: 8754 6700**

Patient Details

First Name:	Last Name:
Previous last name:	
Date of birth:	
Address:	
Suburb:	Postcode:
Home phone:	Mobile:
Medicare no.:	
ATSI status: ❑Yes ❑No	Interpreter required: ❑Yes ❑No
Specify language:	
Country of origin:_________________	Year of arrival if known:______________
Previous Mercy patient: ❑Yes ❑No	DVA number:

Referring Doctor Details

Name:
Practice Name:
Practice address:
Suburb: Postcode:
Ph:
Fax:
Provider number:
Date:

Clinic requested

Clinic Name:	Clinic Doctor (if known):

Reason for patient referral

Clinical information

Alerts:
Allergies:
BMI:

Relevant investigation / test results

Current medication

Drug name	Ltd. elapse	Strength	Dose / frequency / special

Past medical history

Relevant social history

Other notes (eg current services)

Doctor's signature: ______________________ Date: ______________________

Appointment details will be sent to referring GP and patient.

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This form constitutes a valid referral to Werribee Mercy Hospital provided all requested details are complete.