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| Mercy Hospital for WomenOutpatients Referral |  | **Referral Date:** 28/11/2019  |

 Outpatient contact details

**Fax number for all referrals: 8458 4205 Outpatient enquiries: ph 8458 4111**

 Clinic requested

|  |  |  |  |
| --- | --- | --- | --- |
| Specialty: |  | Clinic Doctor (if known) |  |

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|  Patient Details |
| Last/Family name: | First name: |
| Previous last name: | Sex: Choose an item. |
| Date of birth: | ATSI status: Choose an item. |
| Address: | Home telephone No.: |
| Suburb: | Mobile number: |
| Postcode: | Email: |
| NOK/Carer: |  Preferred contact method: |
| NOK relationship: |  Medicare no.: |
| NOK contact no.: | Pensioner/Concession/Health/DVA No.: |
| Interpreter required: [ ]  Yes [ ]  No Specify language: |
| Previous Mercy patient: [ ]  Yes [ ]  No  | Mercy UR Number (if known):  |
| The patient has agreed to the referral and the sharing of their personal and health information with the health service [ ]  Yes [ ]  No  |

 Referring Doctor Details

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Doctor: |  |  Provider number: |  |
| Practice Name: |  |
| Practice Address: |  |
| Suburb: |  |
| Postcode: |  | Phone No: |  |
| Email: |  | Fax: |  |
| Preferred method of communication: |  |

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| **Patient’s usual GP** (if not the same as referring doctor) |
| Name: |  | Clinic: |  |

 Reason for patient referral / Presenting problem (or working diagnosis)

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 Clinical information

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| Gravida / Para : Last Cervical Screen:  |
| Allergies:  |
| Height (cm): Weight (kg): BMI: |

Relevant investigation / test results

Please attach results as per the Statewide Referral Criteria for Specialist Clinics <https://src.health.vic.gov.au>

**If the required investigation/test results are not attached the referral will not be accepted by Mercy Health**

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Current medication

|  |  |  |  |
| --- | --- | --- | --- |
| Drug name | Ltd. elapse | Strength | Dose / frequency / special |
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Past medical history

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Relevant social history

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Other notes *(eg management to date, current services, impact of the problem on the patient)*

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| --- | --- | --- | --- |
| Doctor’s signature: |  | Date: |  |

**Appointment details will be sent to referring GP and the patient.**

**IMPORTANT NOTICE – PRIVILEGED AND CONFIDENTIAL MESSAGE**

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