|  |  |  |
| --- | --- | --- |
| Mercy Hospital for Women  Outpatients 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) |  |

|  |  |
| --- | --- |
| 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: | |  | | | |

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

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

|  |
| --- |
|  |

Clinical information

|  |
| --- |
| 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**

|  |
| --- |
|  |

Current medication

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

Past medical history

|  |
| --- |
|  |

Relevant social history

|  |
| --- |
|  |

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

|  |
| --- |
|  |

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

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

**IMPORTANT NOTICE – PRIVILEGED AND CONFIDENTIAL MESSAGE**

This facsimile transmission is intended for the exclusive use of the person or hospital to which it is addressed and may contain information that by law is privileged or confidential. If the reader of the facsimile transmission is not the intended recipient, you are hereby notified that any disclosure, distribution of copying of this transmission is prohibited by law, and the contents must be kept strictly confidential. If you have received this transmission in error, kindly notify us immediately and return the original to us at the above address.

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