# Mercy Hospital for Women Outpatients Referral		**Referral Date:**

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:
Date of birth:	ATSI status:
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

D.O.B.

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.

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