

Mercy Hospital for Women

Outpatients Referral



Referral Date: 24/01/2025

Outpatient contact details

Fax number for all referrals: 8458 4205

Outpatient enquiries: ph 8458 4111

Clinic requested

Specialty:

Clinic Doctor (if known)

Patient Details

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|--|--|
| 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: |
| Preferred contact method: | Medicare no.: <input type="checkbox"/> Non eligible |
| NOK/Carer: | Reference: |
| NOK relationship: | Private Health Fund: |
| NOK contact no.: | Private Health No.: |
| Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No | Specify language: |
| Previous Mercy patient: <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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)

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|-------|---------|
| 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.

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