# 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

| | |
|---|---|
| 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.: Reference: ☐ Non eligible |
| NOK/Carer: | Private Health Fund: |
| NOK relationship: | Private Health 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 |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |
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| | | | |
| | | | |

## 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.**