Western Health
General practice referral

Adult Specialist Clinics
Ph 8345 6490 Fax 8345 6856

Women's Clinic
(maternity and gynae) AND
Paediatric Specialist Clinics
Ph 8345 1727 Fax 9055 2125

Patient

Name:

Date of Birth: / /

Sex:

UR Number:

Referral date: / /

Please refer to Melbourne HealthPathways at **http://melbourne.healthpathways.org.au** for guidance in assessing, managing and referring for patient conditions.

Referrals that do not include the required information for triaging, including the **required minimum investigations** as per the HealthPathways and www.westernhealth.org.au will be returned with a request for further information.

Patient details

Name: _____ Title:_____

Preferred name/s:_____ Date of Birth: / /

Address: _____ Sex:

Phone: _____ Aboriginal ☐

Work: _____ Torres Strait Islander ☐

Mobile: _____ Both Aboriginal and Torres Strait Islander ☐

Not Aboriginal or Torres Strait Islander ☐

Alternative contact: _____ No answer ☐

Interpreter required: _____ DVA number: _____

Preferred language: _____ Insurance: _____

Pension card number: _____ Medicare number: _____

Referring General Practitioner

Name: _____

Address: _____

Phone: _____

Fax: _____

Provider number: _____

Specialist Clinic requested

Clinic Head of Unit name:

Reason for Patient Referral (please clearly specify reason for referral)

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Clinical information (please attach relevant investigations and name of pathology provider)

Medical past history:

Current medications:

Warnings:

Allergies:

Social history:

Referral duration

☐ 12 months ☐ Indefinite referrals (recommended for ongoing chronic conditions)

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