Outpatient Referral

Referral Date: / /

GP Review Date: / /

Feedback Requested: ☐ Yes ☐ No

Referral to:

Consulting Clinics, Caulfield Hospital

260 Kooyong Rd, Caulfield. 3162

Phone: 9076 6800

Fax: 9076 6435

Referring General Practitioner (stamp):

Clinic or Specialist requested:

Patient details

Name:

Date of Birth: / /

Preferred name/s:

Sex: ☐ Male ☐ Female

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Address:

Phone: Work:

Mobile:

Email:

Alternative Contact:

Indigenous Status:

Period of referral: ☐ 3 months ☐ 12 months ☐ Indefinite

Reason for patient referral

Other notes (eg current services)

Interpreter required:

Preferred language is:

Pension Card Number:

DVA Number:

Insurance:

Medicare Number:

Consent to referral and sharing of relevant information: ☐ Yes ☐ No

Attach 'Patient Consent Form' if restrictions apply.

Referring doctor: Patient name: Date: / /

GP Referral

Date Created: June 2010
Printed From Intranet

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Outpatient Referral

Caulfield HOSPITAL

Clinical information

Warnings:

Allergies:

Current Medication:

Drug name	Ltd. elapse	Strength	Dose / frequency / special

Social History:

Past Medical History:

Investigation / Test Results: Please attach.

Please fax this referral to Caulfield Hospital Consulting Suites: 9076 6435

Please note that the absence of required information may lead to delays in processing the referral and subsequent appointment allocation

Referring doctor: Patient name: Date: / /

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