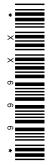
Outpatient Referral



| Referral Date: | / | | / | | |
|-----------------|------|----|---|-----|------|
| GP Review Date: | | / | | / | |
| Feedback Reque | stee | d: | | 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: | Address: | | | |
|--|--------------|--|--|--|
| Date of Birth: / / | | | | |
| Preferred name/s: | Phone: Work: | | | |
| Sex: 🗌 Male 🔲 Female | Mobile: | | | |
| Title: 🗌 Mr 🗌 Mrs 🗌 Ms 🗌 Miss | Email: | | | |
| Alternative Contact: | | | | |
| Indigenous Status: | | | | |
| Period of referral: 3 months 12 months | | | | |

DVA Number:

Medicare Number:

🗌 No

Insurance:

Reason for patient referral

Other notes (eg current services)

Attach 'Patient Consent Form' if restrictions apply.

Consent to referral and sharing of relevant information:
Yes

| Interpreter required: |
|------------------------|
| Preferred language is: |
| Pension Card Number: |
| |

| June 2010 | Intranet |
|---------------|--------------|
| Date Created: | Printed From |

Page 1 of 2

| Referring | doctor: |
|-----------|---------|
|-----------|---------|

Patient name:

Date: / /



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

Referring doctor:

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Date Created: June 2010 Printed From Intranet

Patient name: