|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last name\* |  | First name/s\* |  | Date of birth\* |  |
|  \*mandatory fields* The patient will be contacted by the Alfred Burns Outpatients, with appointment details
* Burns Unit: The Alfred, 55 Commercial Road, Melbourne, VIC, 3044

T 03 9076 3626 E bna@alfred.org.au |
| **Patient Portal** The Patient Portal enables patients to easily access their Alfred Health appointment and health information online. Patients are encouraged to register, once they have received a Medical Record Number.  |
| **Patient details** |
| Sex at birth | [ ]  Female[ ]  Male [ ]  Other | Alfred Health MRN*If known* |  |
| Gender identity | [ ]  Female[ ]  Male [ ]  Non binary [ ]  Not stated[ ]  Prefer not to answer [ ]  Different term |
| Preferred name |  |
| Address |  |
| Telephone |  | Email |  |
| Medicare No |  | Reference No |  | Expiry |  | NDIS No |  |
| [ ]  Bulk Bill [ ]  Private [ ]  Pensioner [ ]  TAC [ ]  WorkCover [ ]  Other |  |
| Interpreter | [ ]  Yes [ ]  No | Language |  |
| Aboriginal status | [ ] Not Aboriginal or Torres Strait Islander[ ] Torres Strait Islander not Aboriginal[ ] Aboriginal not Torres Strait Islander | [ ] Aboriginal and Torres Strait Islander[ ] Prefer not to answer[ ] Not specified |
| Cultural / support needs |  |
| Contact person name |  | Relationship |  | Phone |  |
| Medical Treatment Decision Maker name |  | Relationship |  |
| GP Name |  | GP Address |  |
| **Reason for referral** |
| Total Body Surface Area  |  | Location |  |
| Mechanism of injury |  |
| Date of injury |  | Age at date of injury |  |
| Injury details |  |
| **Medical history** |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last name\* |  | First name/s\* |  | Date of birth\* |  |

|  |  |  |
| --- | --- | --- |
| Allergies [ ]  Yes [ ]  No | List |  |
| **Surgical history** |
|  |
| **Psychosocial / family history** |
|  |
| **Current / ongoing issues** |
|  |
| **Future surgery / plans** |
|  |
| **Additional information**Wound images – *attach if available* |
|  |
| **Desired review timeframe** | [ ]  < 3 Months [ ]  3 Months [ ]  6 Months  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referrer details** | Date of referral / transfer of care |  | Provider No |  |
| Name |  | Address |  |
| Telephone |  | Fax |  |
| Email |  | Copies to |  |

Return referral to BNA@alfred.org.au

**Clinical Images** (*add as many pages as required*)