|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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](mailto:BNA@alfred.org.au)

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