Outpatient Specialist Clinic Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

Date of Birth ..../..../.... Age .....

Doctor ..... Ward .....

Address .....

PATIENT LABEL

PLACE LABEL HERE

Referral Date: ____ /____ /_____ Feedback requested: ☐ Yes ☐ No

Referral to:

Name: _____

Service: _____

Address: Access Department
PO Box 120, Wonthaggi VIC 3995

Phone: 5671 3175 Fax: 9102 5307

Email: Access@basscoasthealth.org.au

Referring Doctor (stamp):

Name: _____

Provider Number: _____

Address: _____

Phone: _____

Fax: _____

Signature: _____

Period of referral:

☐ 3 months ☐ 12 months ☐ Indefinite

Service Requested: ☐ Urgent ☐ Routine

Patient Details:

Name: _____ Preferred name/s: _____

Date of Birth: ____ /____ /_____ Gender: ☐ Female ☐ Male ☐ Other

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Address: _____

Phone: _____ Work: _____ Mobile: _____

Email: _____

Alternative Contact: _____

Indigenous Status: _____

Compensable details: ☐ Public ☐ Workcover ☐ DVA ☐ TAC ☐ Overseas

Reason for patient referral:

_____

_____

_____

_____

_____

Other notes (e.g. current services):

_____

_____

_____

_____

OUTPATIENT SPECIALIST CLINIC REFERRAL MR/309

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PLACE LABEL HERE

Interpreter required: ☐ YES ☐ NO DVA Number: _____

Preferred language is: _____ Insurance: _____

Pension Card Number: _____ Medicare Number: _____

Consent to referral and sharing of relevant information: ☐ YES ☐ NO

Clinical Information

Warnings: _____

Allergies: _____

Current Medication:

Drug name	Ltd. Elapse	Strength	Dose / frequency / special

Social History:

_____

_____

_____

Past Medical History:

_____

_____

_____

Investigation / Test Results:

_____

_____

Please email this referral to Bass Coast Health's Access Department: Access@basscoasthealth.org.au

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

Office Use Only

Received Date: ____ /____ /_____ Triaged by: _____

☐ Accepted ☐ Rejected ☐ Need further information Clinic Required:_____

Clinic appointment booked: Date ____ /____ /_____ Time: _____

Patient notified by phone/mail: ☐ Yes ☐ No Date: ____ /____ /_____

Notified/processed by: _____

OUTPATIENT SPECIALIST CLINIC REFERRAL

MR/309