 **SPECIALIST CLINICS REFERRAL FORM**

Email: gpopreferral@austin.org.au Telephone: (03) 9496 2900 Fax: (03) 9496 2097

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| REFERRAL SOURCE / DR STAMP:DrAddress:Phone:Fax:Provider No:Email:Signature: DATE OF REFERRAL:  | CLIENT DETAILS:Name: Address:Male/FemalePhone: Home: Mobile: Date of Birth:Email:Medicare No: /  |

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| UNIT REQUIRED: | HEAD OF UNIT: |

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| REASON FOR REFERRAL: |

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| REFERRAL VALID FOR: |

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| CLIENT INFORMATION: |  |  |  |
| Is the patient Aboriginal? | Yes or No | Is the patient a veteran? | Yes or No |
| Is the patient Torres Strait Islander? | Yes or No | DVA No:  |
| Has the patient attended this hospital? | Yes or No | Transport required? | Yes or No |
| Austin UR:  |  | Interpreter required? If Yes: which language?: | Yes or No |
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| CLINICAL URGENCY: Urgent or Routine |

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| CURRENT MEDICATIONS:Attached: Yes or No | PAST HISTORY:Attached: Yes or No | RECENT INVESTIGATION RESULTS:Attached: Yes or No |
| ADVERSE REACTIONS & MEDICAL WARNINGS: Attached: Yes or No |

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| SOCIAL FACTORS IMPACTING CARE:  |  |
| Will patient be arriving by ambulance? | Yes or No |
| Does person live alone? | Yes or No |
| Does the person have caring responsibilities for others? | Yes or No |
| Has the person been receiving community support services | Yes or No |
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| Please indicate if the patient may require assistance from the below services: |
| Dietician: Yes or No |  Physiotherapy: Yes or No | Social Work: Yes or No | O.T: Yes or No |
| Other: |

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