 **SPECIALIST CLINICS REFERRAL FORM**

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

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| REFERRAL SOURCE / DR STAMP: Dr  Address:  Phone:  Fax:  Provider No:  Email:  Signature: DATE OF REFERRAL: | CLIENT DETAILS: Name:  Address:  Male/Female  Phone: 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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