

REFERRAL OUTPATIENT CLINIC CHW

Copies available through www.chw.edu.au

FAX TO 9845 0566

MRN _____

NAME _____

DOB _____ SEX _____

(PLEASE AFFIX CHW PATIENT LABEL IN THIS BOX)

Your patient will receive a letter with the details of their scheduled appointment. For all enquires please telephone 9845 2525

Patient details

Surname: _____ Given names: _____

Date of birth: _____ Sex: Male Female

Address: _____

Preferred contact number: _____

Mobile* _____ Other _____

Language spoken at home: _____

Interpreter required: Yes No

*** Mobile Number used to send SMS reminder before appointment**

Clinical details - Outpatient consultants and clinic information, available at www.chw.edu.au

Consultants Name _____ Clinic required _____

Reason for referral / diagnosis: _____

Relevant past history: _____

Please include relevant medications, pathology and imaging results with this referral

Assessment of Priority - ≤ 30 days ≥ 30 days Routine/ Follow-Up

Referral duration: 3 months 12 months Indefinite Other _____

Referring doctor details

Surname: _____

Given name: _____

Provider number: _____

Address: _____

Telephone number: _____

Fax number: _____

Doctor's signature: _____

Date _____

Preferred contact: Telephone Fax

*Practice stamp
(if available)*