

Referrals
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GP Liaison phone: +61 3 8387 2161
Outpatient referrals fax (Parkville): +61 3 9342 4234
Direct Access Unit fax (Royal Park): +61 3 8387 2217

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## Referral form

К	e	eı	ra	l to

Department	Referral date				
Practitioner's name (if not listed)	Find more names at thermh.org.au/our-doctors				
Address (if known)					
Referral from					
Referring GP name	Provider number				
Clinic name					
Clinic address					
Patient / client details					
Surname	Address				
First name/s					
Preferred name/s	Phone				
Title (choose or specify)	Email				
Gender (choose from list)	Alternative contact person				
Pronouns (choose or specify)	Alternative contact phone				
Date of birth (dd/mm/yyyy)	RMH UR number (if known)				
	Medicare number				
Interpreter required Yes □ No □	Health insurance				
Preferred language	Pension card number				
Is the patient Aboriginal Yes □ No □ and/or Torres Strait Islander?	Department of Veteran's Affairs (DVA) number				

Attach 'Patient Consent Form' if restrictions apply.

Yes □ No □

## **GP** referrals

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Referral reasons			
	Telehealth consu	ultation request?	Yes □ No □
Referral details (presenting problem or working diagnosi	S) <u>Statewide ref</u>	erral criteria   HealthPa	athways Melbourne
Additional information (incl. social history, current treatn	nent, past medical h	istory and curren	t services)
Clinical information			
Clinical information  Alerts			
Allergies			
Current medication	<b>2</b> 1	D //	,
Drug name	Strength	Dose / frequen	cy / special
Investigation / test results			

