

# Werribee Mercy Hospital

## Outpatients Referral



Referral Date: 9/07/2024

### Outpatient contact details

Fax number for all referrals: 8754 6710

Outpatient enquiries: ph. 8754 6700

### Clinic requested

Specialty:	Clinic Doctor (if known)
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### Patient Details

Last/Family name:	First name:
Previous last name:	Sex: Choose an item.
Date of birth:	ATSI status: Choose an item.
Address:	Home telephone No.:
Suburb:	Mobile number:
Postcode:	Email:
Preferred contact method:	Medicare no.: <span style="float: right;">Reference:</span> <input type="checkbox"/> Non eligible
NOK/Carer:	Private Health Fund:
NOK relationship:	Private Health No.:
NOK contact no.:	Pensioner/Concession/Health/DVA No.:
Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No Specify language:	
Previous Mercy patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	Mercy UR Number (if known):
The patient has agreed to the referral and the sharing of their personal and health information with the health service <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Referring Doctor Details

Referring Doctor:	Provider number:
Practice Name:	
Practice Address:	
Suburb:	
Postcode:	Phone No:
Email:	Fax:
Preferred method of communication:	

### Patient's usual GP (if not the same as referring doctor)

Name:	Clinic:
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### Reason for patient referral / Presenting problem (or working diagnosis)

## Clinical information

Gravida / Para :	Last Cervical Screen:	
Allergies:		
Height (cm):	Weight (kg):	BMI:

## Relevant investigation / test results

Please attach results as per the Statewide Referral Criteria for Specialist Clinics <https://src.health.vic.gov.au>

**If the required investigation/test results are not attached the referral will not be accepted by Mercy Health**

## Current medication

Drug name	Ltd. elapse	Strength	Dose / frequency / special

## Past medical history

## Relevant social history

## Other notes *(eg management to date, current services, impact of the problem on the patient)*

Doctor's signature:	Date:
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**Appointment details will be sent to referring GP and the patient.**

### IMPORTANT NOTICE – PRIVILEGED AND CONFIDENTIAL MESSAGE

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This form constitutes a valid referral to Werribee Mercy Hospital provided all requested details are complete.