Government of **Western Australia**
Department of **Health**

REQUEST FOR SPECIALIST OUTPATIENT APPOINTMENT

HOSPITAL: ……

SPECIALITY/CLINIC: ……

NAME OF SPECIALIST PREFERRED: ……..

Has the patient been seen by this hospital before? YES □ NO □ Year: ……..
Has the patient been referred to this clinic/speciality for the same condition before? YES □ NO □
Is the patient suitable for Telehealth consultation (rural only)? YES □ NO □

PATIENT DETAILS: Hospital No: | | | | | | | | |

Medicare No: | | | | | | | | | | | Ref No: ……Exp …../…../……

Please circle if applicable for this referral: DVA White / DVA Gold: Number:……..
M.V.I.T / Workers Compensation

Date of Birth: …… Male / Female – Marital Status: M / S / W / D / Sep / Defacto

Country of Birth: …….. Aboriginal / Torres Straight Islander /Neither

Surname: …….. Previous name (e.g. Maiden name): ……

First Names: …… Preferred name / Title: ……

Address: ……

Mailing Address *(if different)*: ……..

Phone: Home: ……..... Work: …… Mobile: ……..

NEXT OF KIN:

(Essential if under 18 years/Guardian)

Relationship: ……..

First name: ……

Surname: ……

Phone: ……

SPECIAL NEEDS:

If interpreter required please specify language and dialect:

……..

Other special needs: ……

……..

LENGTH OF REFERRAL: 12 months: □
Other *(please specify)*……..

REFERRING DOCTOR:

Name: .....

Address: ……

……..

Post code:……

Phone: ……

Fax: .....

Usual GP: As above

Other - Name:

……

Suburb: ……

REFERRAL RECOMMENDATION:

This patient needs to be seen (*please tick*):

□ Routine
□ Urgent
□ CPAC Category – Please tick: 1 □ 2 □ 3 □ 4 □ 5 □
□ Discussed with Registrar/Consultant
Name: ……
Appointment date given (*if applicable*)……..

***If applicable**:*

□ Notify GP of appointment details
□ Notify GP if patient does not report for appointment

REFERRAL LETTER

REASON FOR REFERRING (please tick more than one if applicable)

- ☐ **Assessment Only**
- ☐ **Assessment and Management**
- ☐ **Hospital to Share Management with GP**
- ☐ **Diagnostic Procedure**
- ☐ **Suitable for Day Surgery**
- ☐ **Second Consultant Opinion**

Dear Dr .....

Re: (Patient name): ……

Current Problem:

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Past History:

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Current Medications:

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Allergies:

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OTHER (Social, Occupational, Family)

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PLEASE ATTACH COPIES OF ANY RELEVANT INVESTIGATIONS / REPORTS / LETTERS

……...../……/……

Doctor's Signature / Provider Number / Date