South West Healthcare

Department of Medicine
Level 3, South West Healthcare
Ryot Street
Warrnambool VIC 3280

Specialist Outpatient Clinic Referral

ABN: 41189754233

Tel: (03) 5563 1256
Fax: (03) 5563 1206
Email: specialistclinic@swh.net.au
Specialist Physicians webpage

PLEASE ENSURE THAT ALL SECTIONS ON THIS FORM ARE COMPLETED TO ALLOW FOR APPROPRIATE TRIAGE

Referrer Details:		**Date:**
Doctor Name: Practice Name: Practice Address: Phone: Doctor's Signature:	Fax:	Provider Number: Email:

Patient Details:

South West Healthcare UR No (if known):

Surname: Given Name: ☐ Male ☐ Female ☐ Other

Date of Birth: Medicare No:

Address:

Home phone: Mobile phone: Email:

Interpreter Required:	☐ No	☐ Yes – Language:
Is the patient of Aboriginal or Torres Strait Island descent:	☐ No	☐ Yes, please specify:
Is the patient a veteran?	☐ No	☐ Yes, DVA No:
Transport required?	☐ No	☐ Yes

Specialist input sought:

☐ Diabetes Mellitus Type 1	☐ Rheumatology	☐ Post SWH Admission follow up
☐ Diabetes Mellitus Type 2	☐ Nephrology/Renal Medicine	Team Colour
☐ Endocrinology	☐ Neurology	
☐ General & Acute Care Medicine	☐ Stroke/TIA	
☐ Heart Failure Services	☐ Haematology	Requesting Consultant Name
☐ Gastroenterology Services	☐ Geriatric Medicine	

REASON FOR REFERRAL:

Allergies/Adverse Reactions:	**Current Medications & Dosage:** (either complete or attach list)

Relevant Past Medical History:

Relevant investigations and results (<u>please refer to the referral guidelines for this clinic</u>): (Please attach copies)

Current management plan in place for the clinical issue: