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

South West Healthcare

General Medicine Specialist Outpatient Clinic Referral

ABN: 41189754233

Level 4, South West Healthcare
Ryot Street
Warrnambool VIC 3280

Tel: (03) 5563 1256
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Email: specialistclinic@swh.net.au

To: Dr James Gome

Referrer Details:	**Date:**
Name:	
Provider Number:	
Practice Name:	
Practice Address:	
Phone:	Fax:

Patient Details:

South West Healthcare UR No (if known):
Surname:
Given Name:
Date of Birth:
Address:
Home phone: Mobile phone:
Interpreter Required: ☐ No ☐ Yes - Language:
Medicare No:

Specialist input sought:

☐General Medicine
☐Diabetes Mellitus (type 1)
☐Diabetes Mellitus (type 2)
☐Heart Failure Services
☐Renal Medicine (including Haemodialysis / Transplant / Chronic Kidney Disease)
☐Endocrinology

What is the clinical question needing to be addressed AND what is the desired outcome from the referral?

Clinical question:

Desired outcome:

Allergies:

Relevant Past Medical History:

Current Medications and Dosage:

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

Referring clinicians assessment of clinical urgency:

☐Urgent

☐Next available appointment

Current management plan in place for the clinical issue:

Impact of the problem on the patient (i.e. functional impairments, impact on work, impact on caring responsibilities)

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Referring Doctor Signature:

Provider Number:

Date: