South West Healthcare

General Medicine Specialist Outpatient Clinic Referral

ABN: 41189754233

Level 4, South West Healthcare
Ryot Street
Warrnambool VIC 3280

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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 (please refer to the referral guidelines for this clinic):
(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)

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

Referring Doctor Signature: ……………………………………………………………………

Provider Number: ………………………………………………………………………………….

Date: …………………………………………………………………………………………………..