South West Healthcare

Virtual Internal Medicine Team Referral

Department of Medicine
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Specialist Physicians webpage

PLEASE ENSURE THAT ALL SECTIONS ON THIS FORM ARE COMPLETED. INCOMPLETE FORMS WILL BE RETURNED.

Referrer Details:		**Date:**
Doctor Name:		Provider Number:
Health Service:		Name of SWH VIMT Personnel Spoken to:
Referring Unit:		Date of Conversation with SWH VIMT Personnel:
Phone:	Fax:	Email:
Doctor's Signature:		

Patient Details:			
South West Healthcare UR No (if known):			
Surname:	Given Name:		Gender:
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
Is the patient a current HARP client		☐ No	☐ Yes

REASON FOR REFERRAL & CURRENT MANAGEMENT PLAN:

Relevant Past Medical History:

Current Medications & Dosage: (either complete or attach list)

Allergies / Adverse Reactions:

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

Clinical urgency:

☐ Urgent (Within 1 - 2 Business Days) ☐ Semi Urgent (> 3 Business Days)

PLEASE ENSURE THAT YOU HAVE SPOKEN TO THE SWH VIMT REGISTRAR PRIOR TO COMPLETING & SUBMITTING THIS FORM.
THE VIMT REGISTRAR CAN BE CONTACTED VIA THE SWH SWITCHBOARD (03) 5563 1666

PLEASE SUBMIT A COMPLETED COPY OF THIS FORM VIA FAX: (03) 5563 1206 OR EMAIL: specialistclinic@swh.net.au