Austin Health OUTPATIENT DEPARTMENT

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OUTPATIENT REFERRAL FORM

REFERRAL SOURCE:
PLEASE PRINT CLEARLY AND USE BLACK INK WHEN POSSIBLE

Name:
Address:
Telephone: Fax:
Email address:
Provider No: Date of Referral:

REASON FOR REFERRAL:

UNIT REQUIRED:
HEAD OF UNIT:

Length of Referral: 3 months ☐ 6 months ☐ 12 months ☐ indefinite ☐

CLIENT DETAILS Please tick if appropriate

Has the patient attended Austin Health previously Yes ☐ Austin Health UR_____

Name: Male ☐ Female ☐

Address: DOB:_____

Telephone (Home): Work: Mobile:

Is the patient Aboriginal ☐ Torres Strait Islander ☐

Is the patient Workcare ☐ TAC ☐

Is the patient a Veteran ☐ Veteran Number_____ DVA Transport Required Yes ☐ No ☐

Private Insurance ☐ Fund Name_____ Member Number_____

Does the patient require the assistance of an interpreter Yes ☐ No ☐ Language _____

Please nominate which language/dialect_____

CLINICAL URGENCY: Please tick the appropriate box indicating clinical urgency:
0-5 days ☐ 6-10 days ☐ 11-15 days ☐ 16-20 days ☐ 20> days ☐ Other_____

CURRENT MEDICATIONS:
Attached Yes ☐ No ☐

RECENT INVESTIGATIONS RESULTS:
Attached Yes ☐ No ☐

PAST HISTORY:

SOCIAL FACTORS IMPACTING CARE: Please tick if appropriate

Please indicate if patient is arriving by ambulance ☐
Does person live alone ☐
Does the person have caring responsibilities for others ☐
Has the person been receiving community support services ☐

Please indicate if the patient may require assistance from the below services:
Dietician ☐ Physiotherapy ☐ Social Work ☐ O.T. ☐ Other:_____