



BCH
Bass Coast Health

Outpatient Specialist Clinic Referral

Surname U.R. No.
 First Name Gender
 Date of Birth / / Age
 Doctor Ward.....
 Address

PLACE LABEL HERE

Referral Date: ____ / ____ / ____

Feedback requested: Yes No

Referral to:

Speciality:

Name:

(only if applicable)

Address: Access Department
PO Box 120, Wonthaggi VIC 3995

Phone: 5671 3175 Fax: 9102 5307

Email: Access@basscoasthealth.org.au

Referring Doctor (stamp):

Name:

Provider Number:

Address:

Phone:

Fax:

Signature:

Period of referral:

3 months 12 months Indefinite

Service Requested: Urgent Routine

Patient Details:

Name: Preferred name/s:

Date of Birth: ____ / ____ / ____ Sex at birth: Gender:

Title: Mr Mrs Ms Miss

Address:

Phone: Work: Mobile:

Email:

Alternative Contact:

Indigenous Status:

Compensable details: Public Workcover DVA TAC Overseas

Reason for patient referral:

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Other notes (e.g. current services):

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OUTPATIENT SPECIALIST CLINIC REFERRAL

MR/309



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Interpreter required: YES NO DVA Number:

Preferred language is: Insurance:

Pension Card Number: Medicare Number:

Consent to referral and sharing of relevant information: YES NO

Clinical Information

Warnings:

Allergies:

Current Medication:

Drug name	Ltd. Elapse	Strength	Dose / frequency / special

Social History:

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Past Medical History:

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Investigation / Test Results:

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Please email this referral to Bass Coast Health's Access Department: Access@basscoasthealth.org.au

Please note that the absence of required information may lead to delays in processing the referral and subsequent appointment allocation.

Office Use Only

Received Date: ____ / ____ / ____ Triaged by:

Accepted Rejected Need further information Clinic Required:

Clinic appointment booked: Date ____ / ____ / ____ Time:

Patient notified by phone/mail: Yes No Date: ____ / ____ / ____

Notified/processed by:

MR/309 OUTPATIENT SPECIALIST CLINIC REFERRAL