Outpatient Specialist Clinic Referral

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

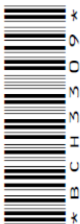
Reason for patient referral:

____
____
____
____
____

Other notes (e.g. current services):

____
____
____
____

OUTPATIENT SPECIALIST CLINIC REFERRAL MR/309


BCH309

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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:

____

____

____

Past Medical History:

____

____

____

Investigation / Test Results:

____

____

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: ____________________________

OUTPATIENT SPECIALIST CLINIC REFERRAL

MR/309