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| **PRINCE OF WALES HOSPITAL**  **ADULT OUTPATIENT DEPARTMENT REFERRAL** |  |

**Date of Referral:**

**Patient Details:**

|  |  |
| --- | --- |
| Full Name  Full Address  Patient Demographics:  Phone (Home)  Patient Demographics: Phone (Mobile)  Date of Birth:  Gender: | Medicare No:  Concession No:  DVA No:  Insurance Fund: |
| **Carer Name:** | **Carer Address:** |
| **Carer Contact:** |  |
| **Clinic Referred to:** |  |
| **Specialist Referred to if not listed above** | Name: |
|  | Addressee: |
| Referral Valid for: |  |
| Clinical Urgency: |  |
| Comment if Urgent: |  |

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| **Reason for Referral:** |

**Clinical Details:**

**Allergies/Adverse Reactions**

**Patient Medical History**

**Current Medication List (Includes Regular and PRN)**

**Immunisations**

**Recent investigations**

|  |  |
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| **Additional Patient Information** |  |
| Has the patient attended Prince of Wales Hospital previously? |  |
| DVA Transport required? |  |
| Does the patient require the assistance of an Interpreter? |  |
| Please nominate which language/dialect |  |

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| **Referral Source** |
| **Referring Doctor**  Name  Practice:Name  Practice:Address  Telephone:  Fax:  Email:  Provider Number: |