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

**Date of Referral:**

**Patient Details:**

|  |  |
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| Full NameFull AddressPatient 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** NamePractice:NamePractice:AddressTelephone: Fax: Email: Provider Number:  |