SEND TO THE WOMEN'S AND CHILDREN'S HOSPITAL

72 King William Road, North Adelaide 5006. Tel (08) 8161 7000

G.P. REFERRAL TO:

PAEDIATRIC EMERGENCY.

ph: 08) 8161 6110

fax: 08) 8161 6142 ☐

PAEDIATRIC OUTPATIENTS

ph: 08) 8161 7399

fax: 08) 8161 6246 ☐

Does this Pt wish to be seen as a

Private Pt yes ☐ **no** ☐

Full name: Please print clearly - Surname first

Date of Birth: | Sex: | U.R. No.

MEDICARE NUMBER

PATIENT'S ADDRESS (to which appointment is sent)

Post code:

Phone: Home

Work

	Yes	No
Seen before at WCH	☐	☐
Born at QVH/WCH	☐	☐

INTERPRETER REQUIRED?

Yes ☐ No ☐

Language:

PREFERRED CLINIC

REFERRAL LETTER. Please include sufficient information to allow prioritisation of requests.
Please write legibly. Please include any pathology, X-ray reports etc.

PAST MEDICAL HISTORY:

SOCIAL HISTORY & SUPPORTS:

CURRENT MEDICATION:

KNOWN ALLERGY:

LENGTH OF REFERRAL

1 YEAR ☐

INDEFINITE ☐

OTHER ☐

Date:

Signature:

REFERRING DOCTOR'S NAME:

FOLLOW UP:

Advice & opinion only ☐

Short-term management ☐

Shared long-term management ☐

PROVIDER NUMBER:

ADDRESS:

PHONE: FAX: