Wadja Health Clinic – A General Medical Outpatient Clinic for Aboriginal/Torres Strait Islander Children

The Royal Children's Hospital Melbourne

REFERRAL FORM

PATIENT DETAILS

SURNAME:____________________________ GIVEN NAMES: ______________________________

Date of birth: _________/____/_____ Sex (please circle) : Male / Female

Address: ____

____

Preferred contact number: (1) _________________________ (2) ___________________________

Medicare number: ____

☐ Aboriginal ☐ Torres Strait Islander ☐ Both

REFERRAL DETAILS

Reason for referral / diagnosis:

____

____

____

Relevant past history:

____

____

____

REFERRING DOCTOR DETAILS

Surname: ____________________________________ Given name: ________________________

Provider number: ____

Address: ____

Preferred contact number: ____

Fax number: ____

Doctor's signature: __________________________________ Date: ____________________

Practice stamp (if available)

Ph: 9345 6111 Fax: 9345 4378

Post to: *Wadja* Health Clinic, *Wadja* Aboriginal Family Place

The Royal Children's Hospital, 50 Flemington Road, Parkville VIC 3052