



OUTPATIENT CLINIC REFERRAL FORM

Fax to 03 9345 5034

Please complete all sections of this form clearly and legibly. Your patient will receive a letter by mail advising them of the details of their scheduled appointment. You will receive a letter from the RCH doctor that sees your patient.

Patient Details
Surname: _____ Given names: _____
Date of birth: _____ Sex: Male [] Female []
Address: _____
Preferred contact number: (1) _____ (2) _____
Medicare number: _____
Language spoken at home: _____ Interpreter required: Yes [] No []

Clinical Details (a list of clinics is available at www.rch.org.au/outpatients)
Clinic required _____ OR [] RCH to determine appropriate clinic
Reason for referral / diagnosis: _____
Relevant past history: _____
Please include a list of current medications, any relevant pathology and imaging results with this referral. This information will assist us to appropriately triage your patient.
Referral duration: [] 3 months [] 12 months [] Indefinite [] Other _____

Referring doctor details
Surname: _____ Given name: _____
Provider number: _____
Address: _____
Preferred contact number: _____
Fax number: _____
Doctor's signature: _____
Date: _____
Practice stamp (if available)

Office use only
Date received _____ Clinic _____ Triage _____