FRC102025

The Royal **Children's** Hospital Melbourne

RCH Specialist Clinics Referral

Fax to (03) 9345 5034
Specialist clinic queries telephone (03) 9345 6180

Please note: A typed referral is preferred as it is much clearer to read and triage after faxing.

You will receive confirmation of receipt of your referral within two weeks and your patient will receive a letter by mail closer to the next available appointment time, asking them to call and book an appointment.

Primary Care Liaison
www.rch.org.au/kidsconnect: Pre-referral Guidelines, Clinical Services Directory, contact information, referral forms for Specialist Clinics, Medical Imaging, Pathology and more.

Parent Info Factsheets www.rch.org.au/kidsinfo

Patient details

Surname	**Given names**
Date of birth	**Sex** ◯ **Male** ◯ **Female**
Address	**Postcode**
Preferred contact number: Mobile _____ *Mobile number used to send SMS reminder before appointment*	**Other contact number**
Medicare number	**Patient number of card**
Interpreter required ◯ **Yes** ◯ **No**	**Language**

Clinical details *(Clinical Services Directory, Pre-referral Guidelines etc. on Primary Care Liaison website above)*

To Doctor *(specify name)*	**OR** ◯ **at department head's discretion**
Department name	**OR** ◯ **RCH to determine appropriate clinic**
Clinical details	

Please attach a list of current medications, relevant pathology and imaging results with this referral

Referring doctor details *Please ensure your details are up-to-date on the Human Services Directory to ensure correspondence is sent to correct address. Go to www.humanservicesdirectory.vic.gov.au*

Given name	**Referral duration**	**OFFICE USE ONLY**
Surname	◯ **3 months**	**Triaged by**
Provider number	◯ **12 months**	**Date** / /
Address	◯ **Indefinite**	**Presenting complaint**
	◯ **Other** _____	**Clinic required**
Telephone number		**Details**
Fax number		◯ **Urgent** ◯ **Semi-urgent** ◯ **Next available**
Doctor's signature		**Date** / /