The Royal Children's Hospital Melbourne

RCH Specialist Clinics Referral

Fax all referrals to (03) 9345 5034
Telephone enquires (03) 9345 6180 (Monday- Friday 8.30-5.00pm)

Please note: A typed referral is required. Receipt of referral and rejection notifications will be via fax within 8 working days.

Correspondence will be sent to the family when the patient is added to the waiting list or appointment is offered.

Further information:
Specialist Clinics: www.rch.org.au/specialist-clinics
Pre-referral guidelines can be found here

Primary Care Liaison: www.rch.org.au/kidsconnect

Patient info factsheets: www.rch.org.au/kidsinfo

Patient Details *(We require all fields of the patient details to be completed)*

Patient Surname		**Given name**	
Date of birth		**RCH UR Number** *(if known)*	
Gender			
Address			**Postcode**
Parent/Carer surname		**Given name**	
Mobile Number		**Landline number**	
Medicare number		**Ref number**	**Expiry date**
Not Medicare eligible ◯			
Indigenous status	◯ **Aboriginal**	◯ **Torres Strait Islander**	◯ **Not indigenous**
Interpreter required	◯ **Yes** ◯ **No**	**Language**	

Clinical Details

Department *(if known)*		Or	◯ **RCH to determine**
To Doctor *(required for MBS clinics)*		Or	◯ **RCH to determine**
Is this a new referral or continuation of existing referral	◯ **New**	Or	◯ **Continuing**
Reason for referral: *Include your clinical findings, management to date, investigation results, relevant medical and social history, special needs, allergies and any current medications.*			

Referring doctor details

Given name	**Surname**	**Referral duration**
Provider number		◯ 3 months
Practice name		◯ 12 months
Practice address		◯ Indefinite
Telephone Number	**Fax Number**	◯ Other **(please specify)**
Doctors signature	**Date**	_____