Government of Western Australia
South Metropolitan Health Service
Peel Health Campus

REQUEST FOR OUTPATIENT APPOINTMENT
General Adult

Family name:
First name:
DOB:

Referral To	
Speciality:	
Name of Specialist (if required):	
Site:	

Referral From			
Name:			
Provider Number:			
Phone:		**Fax:**	
Address:			
Once completed, please send referral to the Peel Health Campus by email: PHC.Referrals@health.wa.gov.au			

Patient Details			
First Name(s):		**URMN Hospital No: (if known)**	
Preferred Name:		**Family Name:**	
Title:		**Any Previous Name:**	
Country of Birth:		**DoB:**	
If born in WA, name of Hospital:			
ATSI Status:		**Gender:**	
Address:		**Mailing Address (If different):**	
Home:		**Email:**	
Mobile:		**Work:**	
Special Needs:			

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Is an interpreter required?					**If Yes, language/Dialect**						
Any other special needs?											
Medicare Eligible:	**Y**		**N**		**Medicare No:**			**Ref:**			
								Exp:			
DVA Card Number:					**DVA Card Type:**						
MVIT	**Y**		**N**		**Workers Compensation:**			**Y**		**N**	
Next of Kin/Guardian:											
Full Name:					**Phone:**						
Relationship:					**Mother's name at time of Birth:**						

Referral Details											
Fill this box for Immediate Referrals only *(if the Patient must be seen by specialist within 7 days)*											
Has the referral been discussed with Registrar or Consultant?					**Y**		**N**				
If yes, the clinician name:											
Site:					**Phone:**						
Referral advice given:											
Is the referrer the usual GP for the patient?	**Y**		**N**		**If No, name of usual GP:**						
Phone:											
If the patient has been referred to this speciality for the same condition before, do they need to be referred to the same place again?							**Y**		**N**		
Is the patient suitable for a Telehealth consult?							**Y**		**N**		

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Is this a renewed referral?					**Y**		**N**	
Length of Referral:	**3 Months**		**12 Months**		**Indefinite**			
Reason for referring:								

Clinical Information

Observations	**BMI:**		**Height:**		**Weight:**	
Current Problem:						
Past History:						
Current Medications:						
Allergies:						
Other:						
Family:						
Social History:						

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Relevant Investigations and Tests (Please attach)			
Pathology Provider:		**Radiology Provider:**	
Other:			
Doctor Name:		**Provider Number:**	
Designation:		**Date:**	

Hospital Use Triage Only:					
Urgent:		**Semi Urgent:**		**Routine:**	
Comments:					
Name:		**Signature:**		**Date:**	