Government of Western Australia
South Metropolitan Health Service
Peel Health Campus

REQUEST FOR OUTPATIENT APPOINTMENT
Paediatric

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**			
Medicare Eligible:	**Y**		**N**		**Medicare No:**	**Ref:**	
						Exp:	
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**				
Is this a renewed referral?	**Y**		**N**				
Length of Referral:	**3 Months**		**12 Months**		**Indefinite**		
Reason for referring:							

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Clinical Information						
Observations	**Percentile:**		**Height:**		**Weight:**	
Current Problem:						
Past History:						
Current Medications:						
Allergies:						
Other:						
Family:						
Social History:						

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:**	