

# REQUEST FOR A METROPOLITAN HEALTH SERVICES OUTPATIENT APPOINTMENT

(Please print in block letters)

HOSPITAL .....

SPECIALITY/CLINIC .....

SPECIALIST PREFERRED .....

Has the patient previously been seen at this hospital? YES  NO

Has the patient previously been referred to this clinic/specialty for the same condition? YES  NO

**PATIENT DETAILS**

DVA Number (if known)           Medicare Number

Date of Birth    Medical Record Number

Surname ..... Marital Status: S / M / W / D / Sep / Defacto

Preferred Name: ..... Previous Surname: .....  
(eg. Maiden Name)

First Names: ..... Preferred Title: .....

Gender: Male  Female  Country of Birth: .....

Address: ..... Postcode: .....

Phone: Home: ..... Work: ..... Mobile Phone No. ....

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|---|--|
| <p><b>Next of Kin/Guardian:</b><br/><b>(Essential if under 18 years/Guardian)</b></p> <p>Relationship .....</p> <p>Surname .....</p> <p>First Name .....</p> <p>Phone .....</p> | <p><b>Special Needs:</b></p> <p>Please specify language and dialect if interpreter required</p> <p>.....</p> <p>Other special needs .....</p> <p>.....</p> |
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| <p><b>REFERRING DOCTOR</b> (Stamp or print)</p> <p>Name .....</p> <p>Provider No. ....</p> <p>Address .....</p> <p>.....</p> <p>Postcode .....</p> <p>Phone .....</p> <p>Fax .....</p> <p>Email .....</p> <p>Are you the patient's usual GP? YES <input type="checkbox"/> NO <input type="checkbox"/></p> | <p><b>REFERRAL RECOMMENDATION</b></p> <p>This patient needs to be seen (Please tick)</p> <p><input type="checkbox"/> Urgent <input type="checkbox"/> Routine</p> <p>↓</p> <p><input type="checkbox"/> Have discussed case with Registrar/Consultant<br/>(Name) .....</p> <p><input type="checkbox"/> Rural patient - may be suitable for Telehealth<br/>Video Consultation</p> <p><b>IF AN APPOINTMENT HAS BEEN BOOKED</b></p> <p>Date .....</p> <p>Time .....</p> <p>Consultant Name .....</p> |
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# REFERRAL LETTER

**REASON(S) FOR REFERRING** (Please tick more than one if applicable)

- |   |  |
|---|--|
| <input type="checkbox"/> Assessment only                      | <input type="checkbox"/> Diagnostic procedure      |
| <input type="checkbox"/> Assessment & management              | <input type="checkbox"/> Suitable for Day Surgery  |
| <input type="checkbox"/> Hospital to share management with GP | <input type="checkbox"/> Second Consultant opinion |

Dear Dr ..... Re .....  
*(Patient Name)*

**Current Problem** .....

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**Past History** .....

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**Current Medications** .....

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**Allergies** .....

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**Other** (eg. social occupational family) .....

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PLEASE ATTACH COPIES OF ANY RELEVANT INVESTIGATIONS / REPORTS / LETTERS

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

# TEACHING HOSPITAL OUTPATIENT REFERRAL FORM

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This form should be used for referring patients to outpatient appointments at:

1. ROYAL PERTH HOSPITAL
2. FREMANTLE HOSPITAL
3. SIR CHARLES GAIRDNER HOSPITAL
4. PRINCESS MARGARET HOSPITAL FOR CHILDREN

Please send completed forms to the relevant address below.

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## ROYAL PERTH HOSPITAL

Phone: (08) 9224 2083

Fax: (08) 9224 8436

Outpatients Appointments  
Royal Perth Hospital  
Box X2213 GPO  
PERTH 6847

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## FREMANTLE HOSPITAL

Phone: (08) 9431 2966

Fax: (08) 9431 2391

B Block Reception  
Fremantle Hospital  
PO Box 480  
FREMANTLE 6959

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## SIR CHARLES GAIRDNER HOSPITAL

Please address all referrals to the appropriate clinic below:

Outpatient Appointments  
Central Medical Service Unit  
Sir Charles Gairdner Hospital  
E Block 1st Floor  
Hospital Avenue  
NEDLANDS WA 6009

Phone: (08) 9346 2871

Fax: (08) 9346 4878

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## PRINCESS MARGARET HOSPITAL FOR CHILDREN

Fax: (08) 9388 7710 (General referral)

Fax: (08) 9340 8854 (Orthopaedics)

Outpatient Clinics  
Princess Margaret Hospital for Children  
GPO Box D 184  
Perth 6840

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Further supplies of this form can be obtained by contacting the hospitals at the above addresses/phone/fax numbers.