



Government of **Western Australia**  
Department of **Health**

**North Metropolitan Area Health Service**

**REQUEST FOR OUTPATIENT APPOINTMENT**

**PAEDIATRIC OUTPATIENT SERVICE: THERAPY BLOCK  
SWAN KALAMUNDA HEALTH SERVICE**

Re: .....  
*(Patient's Name)*

**When completed please fax  
referral to: 08 9347 5424**

**NAME OF SPECIALIST PREFERRED**

I would like to refer this patient to the Consultant identified below by the tick against his/her name.\*

**\* You have the option of ticking more than one box. Doing so will ensure that your patient will be seen by the first available consultant.**

**CHOOSE NAME OF SPECIALIST(S) PREFERRED**

Paediatrician	Special Interests	Paediatrician	Special Interests
<input type="checkbox"/> Dr Habib Bhurawala	General Paediatrics	<input type="checkbox"/> Dr Arvind Sharma	Paediatric nephrology & General paediatrics
<input type="checkbox"/> Dr Petra Hartmann	General Paediatrics	<input type="checkbox"/> Dr Girish Deshpande	General Paediatrics & Neonatology

**Referrals for Children with complex developmental or behavioural problems like Autism/ADHD/Conduct disorders etc will not be accepted in General Paediatric clinic at SKHS.**

Has the patient previously been seen by this hospital? **YES**  **NO**   
Year.....

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

Is the patient suitable for Telehealth consultation (rural only)? **YES**  **NO**

Swan Kalamunda Health Service, Eveline Road, Middle Swan, Western Australia 6056  
Letters PO Box 195, Midland Western Australia 6936  
Telephone (08) 9347 5922 Facsimile (08) 9347 5933  
ABN: 13 993 250 709  
<http://www.health.wa.gov.au>





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**REFERRAL LETTER**

Dear Colleague

Re: .....  
 (Patient's Name)

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

- |   |  |
|---|--|
| <input type="checkbox"/> Assessment Only                      | <input type="checkbox"/> Diagnostic Procedure      |
| <input type="checkbox"/> Assessment and Management            | <input type="checkbox"/> Suitable for Day Surgery  |
| <input type="checkbox"/> Hospital to Share Management with GP | <input type="checkbox"/> Second Consultant Opinion |

**Current Problem**

.....  
 .....  
 .....

**Past History.**

.....  
 .....  
 .....

**Current Medications.**

.....  
 .....  
 .....  
 .....

**Allergies .**

.....  
 .....

**Other** (e.g. Social, occupational, family)

.....  
 .....

**PLEASE ATTACH COPIES OF ANY RELEVANT INVESTIGATIONS / REPORTS / LETTERS**

**Referring Doctor's name** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Provider Number:** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / **2010**

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