General practice referral

Purpose: to provide a standardised quality referral from general practice to other service providers

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Referral date: dd/mm/yyyy / /

Feedback requested: ☐ Yes ☐ No

Patient /consumer details

Name: Preferred name/s:

Date of Birth: / / Sex: Title:

Address:

Phone: Work: Mobile:

Email Alternative contact: Indigenous status:

Referral to:

Name:

Phone:

Fax:

Email:

Referring General Practitioner:

Name:

Address:

Phone:

Fax:

Email:

Provider number:

Service requested

Priority: ☐ urgent (list reason) ☐ non-urgent

Reason for patient referral

Other notes (for example current services)

Interpreter required: DVA number:

Preferred language: Insurance:

Pension card number: Medicare number:

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Name:

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Sex:

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Clinical information

Warnings:

Allergies:

Current medication: **None known:** ☐

Drug name	Strength	Dose/frequency/special

Social history:

Medical history:

Investigation / Test results / Relevant plans (eg General Practice Management Plan, Team Care Arrangement, Mental Health Treatment Plan):

Referral Acknowledgment: to be completed by agency/practitioner in receipt of referral

☐ To acknowledge a referral you have received, complete this section

From	Name:	Position:
	Organisation:	Phone:
	Email:	Fax:
To	Name:	Position:
	Organisation:	Phone:
	Email:	Fax:

Date referral received: dd/mm/yyyy / /

Status of referral: ☐ Accepted ☐ Wait listed ☐ Rejected (note reason and suggested alternatives)

Estimated date of assessment: dd/mm/yyyy / /

Contact person for further information: ☐ As above (From details) ☐ New contact (Provide in notes)

☐ I agree to participate in the care of this patient under a Team Care Arrangement

Notes: