



# REQUEST FOR OUTPATIENT APPOINTMENT General Adult

Surname:  
First name:  
DOB:

## Referral To

**(URGENT/IMMEDIATE REFERRALS ARE NOT SENT TO CRS, SEND DIRECTLY TO HOSPITAL)**

Speciality:

Name of Specialist (if required):

Site:

## Referral From

Name:

Provider Number:

Phone:

Fax:

Address:

Once completed, please send referral to the **Central Referral Service** by one of the following methods. Please note that for efficiency of process our preferred method is **Secure Messaging**.

Secure Messaging

Healthlink address ID: **crefserv**

See the CRS website for more information on available vendors.

[http://ww2.health.wa.gov.au/Articles/N\\_R/Referral-form-templates](http://ww2.health.wa.gov.au/Articles/N_R/Referral-form-templates)

1300 365 056

Central Referral Service

GPO Box 2566

St Georges Terrace, WA 6831

Fax  
Post

## Patient Details

URMN Hospital No: (if known)

First Name(s):

Family Name:

Preferred Name:

Previous Name (e.g. Maiden):

Title:

Marital Status:

Country of Birth:

Birth Date:

Gender:

ATSI Status:

Address:

Mailing Address (if different):

Post code:

Email:

Telephone No:

Home:

Work:

Mobile:

Fax:



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**Special Needs:**

Is an interpreter required?

If Yes, language/Dialect:

Other Special needs:

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Medicare Eligible:

Medicare No:

Ref:    Expiry:

DVA Card Number:

DVA Card Type:

MVIT

Workers Compensation

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**Next of Kin/Guardian**

Full Name:

Relationship:

Phone:

## 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?  (essential for Urgent Cases)

If yes, the clinician name:

Site:

Contact Number:

Referral advice given:

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Is the referrer the usual GP for the patient?                      YES                      NO

If No, name of usual GP:

Contact number:

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?                      YES                      NO

Is the patient suitable for a Telehealth consult?                      YES                      NO

Length of Referral:     3mths                      12mths                      Indefinite

Is this a renewed referral?                      YES                      NO

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*Reason for referring:*



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## Clinical Information

Observations	BMI:	Height:	Weight:
<b>Current Problem:</b>			
<b>Past History:</b>			
<b>Current Medications:</b>			
<b>Allergies:</b>			
<b>Other:</b>			
<b>Family:</b>			
<b>Social History:</b>			

### Relevant Investigations and Tests (Please attach)

**Pathology Provider:**

**Radiology Provider:**

**Other:**

**Doctor Name:**

**Provider Number:**

**Designation:**

**Date:**

**Hospital Use Triage Only:**

Urgent:  
 Comments:  
 Name:

Semi Urgent:  
 Signature:

Routine:  
 Date: