Government of Western Australia
Department of Health

REQUEST FOR OUTPATIENT APPOINTMENT
Paediatric

Family name:
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
Fax	1300 365 056
Post	Central Referral Service GPO Box 2566 St Georges Terrace, WA 6831

Patient Details

URMN Hospital No: (if known)

First Name(s): **Family Name:**

Preferred Name: **Any Previous Name:**

Title:

Country of Birth: **Birth Date:**

If born in WA, name of Hospital: **Gender:**

ATSI Status:

Address: **Mailing Address (if different):**

Post code: **Email:**

Phone numbers

Home: **Work:**

Mobile: **Fax:**

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Special Needs:
Is an interpreter required? Y ☐ N ☐ **If Yes, language/Dialect:**

Other Special needs:

Medicare Eligible: Y ☐ N ☐ **Medicare No:** **Ref**: **Expiry:**

DVA Card Number: **DVA Card Type:**

MVIT: **Workers Compensation:** Y ☐

Next of Kin/Guardian

Full Name:

Relationship: **Phone:**

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 ☐ **(essential for Urgent Cases)**
If yes, the clinician name:

Site: **Phone:**

Referral advice given:

Is the referrer the usual GP for the patient? ○ **YES** ◉ **NO**

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? ◉ **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**

Reason for referring:

Government of Western Australia
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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: