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

PAEDIATRIC REFERRAL FORM

HOSPITAL..... **SPECIALTY/CLINIC** .....

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

PATIENT DETAILS **First name:** ..... **Surname:** .....

Medicare Number ☐ Reference No: ..... Expiry Date:.....

Date of Birth..... Male / Female

Country of Birth ..... Aboriginal YES ☐ NO ☐

Address.....

Mailing Address (*if different*).....

Phone: Home .....Mobile.....

NEXT OF KIN (parent/guardian)

Relationship.....

First Name.....Surname.....

Phone: Home.....Work.....

Phone: Mobile .....

Address *(if different):* .....

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SPECIAL NEEDS e.g. interpreter: .....

REFERRING DOCTOR

Name.....

Address.....

.....

.....

Phone.....

Fax.....

Usual GP: (If applicable) .....

REFERRAL DETAILS

Current Problem and Reason for Referral:.....

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Duration of this condition:.....

Treatment used: .....

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Diagnostics: **(Please attach copies of any relevant investigations/reports/letters)**

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Height: **Weight:**

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Other clinical problems:

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Medications..... **Allergies**.....

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Doctor's Signature

.....

Provider Number

.....

Date

***Please note: Only completed forms will be accepted**