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

PAEDIATRIC REFERRAL FORM

HOSPITAL **SPECIALTY/CLINIC**

Is the patient suitable for Telehealth consultation (rural only)? Unselected

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

Medicare Number Reference No Expiry Date:

Date of Birth Male / Female Unselected

Country of Birth Aboriginal Unselected

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):*

SPECIAL NEEDS
e.g. interpreter

REFERRING DOCTOR

Name

Address

Phone

Fax

Usual GP:
(If applicable)

REFERRAL DETAILS

Current Problem and Reason for Referral:

Duration of this condition:

Treatment used:

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

Height: **Weight:**

Other clinical problems:

Current Medications:

Allergies:

Doctor's Signature Provider Number Date

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