WESTMEAD SPECIALISTS REFERRAL FORM

Fax Referrals: (02) 96874005 Email Referrals: info@westmeadspecialists.com.au
Website: www.westmeadspecialists.com.au **Telephone:** (02) 9687 4100 or 9687 4000

LOCATIONS: Shop 6, Coles Complex, 29-33 Darcy Road, Westmead 2145 AND
Shop 1, 35 Darcy Road, Westmead (both premises adjacent to each other)
CAR PARKING: Within Coles Complex (first 1.5 hours free)

Please note: A typed/handwritten referral is required. Receipt of referral will be via fax/email within 3 working days. Families will receive SMS confirming receipt of referral (mobile number MUST be included).

Our specialist services (visit www.westmeadspecialists.com.au for detailed list)

Adult:	Cardiologist, Geriatrician, Neurologist
Paediatric:	Allergy, Behavioural and Developemental paediatrics, Endocrinology Gastroenterology, General Paediatrics, Neurology, Neonatology, Sleep Medicine

Patient Details

Patient surname		**Given name**	
Date of birth		**Hosp.number** *(If known to hospital)*	
Gender	◉ **Male** ○ **Female**	○ **Other:**	
Address			**Postcode**
Parent/Carer surname		**Given name**	
Mobile number		**Landline number**	
Medicare number		○ **Not eligible for Medicare**	
Indigenous status	○ **Aboriginal** ○ **Torres Strait Islander**	◉ **Not Indigenous**	
Interpreter required	○ **Yes** ◉ **No**	**Language:**	

Clinical details

Speciality *(if known)*	**OR**
To Doctor *(required for MBS clinics)*	**OR**

Reason for referral: *include your clinical findings, management to date, investigation results, relevant medical and social history and special needs. Include allergies and current medications. Or attach your software generated referral summary*

Referring doctor details

Given name	**Surname**
Provider number	
Practice name	
Practice address	
Telephone number	**Fax number**
Doctor's signature	**Date: / /**

Referral duration

- ○ 3 months
- ◉ 12 months
- ○ Indefinite
- ○ Other (please specify) _____