Prince of Wales Hospital &
Community Health Services

NSW GOVERNMENT

Prince of Wales Hospital
Cognitive Disorders Referral

All fields outlined in red are **mandatory**. Referrals will not be accepted if these fields are incomplete.

Please review our "Information for Health Professionals" page for a list of services that we provide, as well as our inclusion and exclusion criteria.

Specialist referred to (please specify only ONE practitioner): Dr	Clinic referred to: Cognitive Disorders Outpatients Clinic, Prince of Wales Hospital
Date of referral:	Period of referral validity:

PATIENT DETAILS

Surname:	
Given Name(s):	
Gender:	
Date of Birth:	Email:
Address:	
Home Phone No.:	Mobile No.:
Medicare No.:	Medicare Reference No.:
Insurance Fund:	Insurance Member No.:

NEXT OF KIN/CARER'S DETAILS

Full Name:	
Home Phone No.:	Mobile No.:
Address:	

ADDITIONAL INFORMATION

Does the patient require the assistance of an interpreter?	Yes ☐ No ☐
If yes to the above, what language is required?	

Please complete the referral form and fax the form to (02) 9382 0422.

If your patient needs to be seen urgently please call the Prince of Wales Hospital switchboard on (02) 9382 2222 to speak with the speciality Registrar.

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REFERRAL INFORMATION

Reason for Referral:	
Diagnosis or Suspected Diagnosis:	
Clinical Urgency:	
Affected Area of Body or Location of Injury (if applicable):	
Medical History:	
Allergies/Adverse Reactions:	
Current Medication List (regular and PRN):	
Findings from Investigations (please attach results): Your patient must come to their initial appointment with a recent blood test (<6 months - FBC, EUC, LFT, CMP, B12/folate, TFT, fasting glucose) and brain imaging (<12 months - CT or MRI).	
Current Management Plan:	

REFERRAL SOURCE

Referring Doctor's Name:			
Practice Name and Address:			
Phone No.:		Fax No.:	
Signature:		Provider No.:	

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