



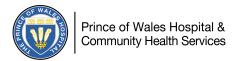
Prince of Wales Hospital Referral to Rheumatology Outpatient Clinics

All fields outlined in red are $\underline{\text{mandatory}}$. Referrals will not be accepted if these fields are incomplete.

Please review the <u>"Information for Health Professionals - Rheumatology"</u> webpage on the POWH website for a list of services provided. Please provide a valid referral (indefinite preferred, otherwise standard annual) made out to one Consultant (for private referrals): Dr James Bertouch, A/Prof Arvin Damodaran, Dr Amel Katrib, Dr Anthony Sammel (Vasculitis Clinic).

Consultant - please specify ONE practitioner for private (bulk-billed) referrals:	Clinic referred to	: Rheumatology Outpatients Clinic, Prince of Wales Hospital	
Dr		Ποσριταί	
Date of referral:	e 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.





Prince of Wales Hospital Referral to Rheumatology Outpatient Departments

REFERRAL INFORMATION

Reason for Referral:		
Diagnosis or Suspected Diagnosis: Include any diagnosis or correspondence from previous care providers		
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 Radiology reports and blood results, including FBC, UEC, LFT, ESR, CRP. If relevant to referral reason, include urate, CK, TFT, BSL, CMP, Vit D, ANA/ENA/DNA/RF/CCP/ANCA. Your patient should bring films or discs to their initial appointment.		
Current Management Plan: Including physical therapy, medications etc.		
REFERRAL SOURCE		
Referring Doctor's Name:		
Practice Name and Address:		
Phone No.:	Fax No.:	
Signature:	Provider No.:	

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