South Eastern Sydney Local Health District

NSW GOVERNMENT

Facility: St George Hospital

REFERRAL – DAY MEDICAL AND INFUSION CENTRE

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010413

Referral to St George Hospital General Medical Unit Consultant

Patient's Phone: _____ Mobile: _____

Patient's email address: _____

Patient's preferred contact: ☐ Mobile ☐ Phone ☐ Email Interpreter Required ☐ Yes ☐ No Language/dialect: _____

Is the patient Aboriginal and/or Torres Strait Islander?

☐ Yes, Aboriginal only ☐ Yes, Torres Strait Islander only ☐ Yes Aboriginal and Torres Strait Islander ☐ No

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ **Expiry Date:** _____/_____/_____

Special needs/reasonable adjustments required for disability: ☐ No ☐ Yes description: _____

To be completed if the patient has a carer.

Name of carer: _____ Phone: _____

Email address: _____

Compensable status: ☐ DVA ☐ WorkCover ☐ Motor vehicle third party insurance ☐ Other _____

Reason for referral: *(e.g. investigation of, type of treatment requesting - dressing, infusion, biopsy, transfusion)*

Treatment required:

If this referral is for medication administration, specify following.

Medication name: _____ **Dose:** _____ **Route:** _____ **Frequency:** _____

If this referral is for venesection, specify volume _____ **mL and frequency:** _____

Diagnosis / Medical History:

HEALTHCARE PRACTITIONER DETAILS			
GP Name		**GP Phone Number**	
GP Address		**GP Fax Number**	
Referring Doctor:		**Provider Number:**	
Contact/Pager Number:	**Referring Doctors Signature:**		**Date of Referral:**

ONCE REFERRAL FORM IS COMPLETE PLEASE FAX TO 9113 1923

OFFICE USE ONLY

Date referral received:		**Treatment Required in:**	☐ Bed ☐ Chair
Accepting Doctor:		**To be seen within:**	
Date Accepted:		**Interpreter Booked:**	☐ Yes ☐ No
Date of Appointment:			☐ Not Available

REFERRAL – DAY MEDICAL AND INFUSION CENTRE
SES010.413

NHSIS06380A 211223

NO WRITING