Queensland Government

Metro South Hospital and Health Service

(**MSHHS USE ONLY** – affix patient identification label here)

Specialist Referral

Fax completed form to Metro South Hospital and Health Service Referrals on 1300 364 248

- **To ensure a timely appointment complete all sections. Incomplete forms will be returned for completion.**
- **Information and resources are available at http://metrosouth.health.qld.gov.au/referrals/paediatrics**
- *Please direct an acutely unwell child to the Emergency Department*

Refer to a Specialty by selecting a **Head of Paediatrics** from the list below. Referrals are shared with other Specialists in the clinic to ensure patients are seen as quickly as possible.

☐ Dr Jan Cullen ☐

OR referral to (named specialist)**:**

REFERRAL DATE:

Length of Referral: ☐ 3 months (standard referral from a Specialist) ☐ 12 months (standard referral from a GP) ☐ Indefinite (chronic conditions only)

PATIENT DETAILS [Referral of new patients are accepted before their 17th birthday]

Name: **Sex:** ☐ M ☐ F **Date of birth:** **Age:**

Medicare eligible: ☐ No ☐ Yes ▸ Medicare no:

Card reference no: Expiry date:

Residential address:

Suburb: **State:** **Postcode:** **Ph (home):**

Parent/Guardian/Agency name: **Relationship to patient:**

Parent/Guardian/Agency contact details:

Aboriginal or Torres Strait Islander status:

☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin ☐ Not stated

☐ Both Aboriginal and Torres Strait Islander origin ☐ Neither Aboriginal, nor Torres Strait Islander origin

Ethnicity:

Interpreter required? ☐ No ☐ Yes ▸ preferred language:

Private health insurance: ☐ No ☐ Yes

Compensable status: ☐ Third Party ☐ Personal injury ☐ Workcover Qld ☐ DVA

DO NOT WRITE IN THIS BINDING MARGIN

v15.04 - 10/2015

Continued next page

Family name:	Given names:	URN:

REASON FOR REFERRAL

Please explain if you consider the referral urgent:

Past medical history:

Current medications:

Allergies:

Immunisation status:

Social history and/or psychosocial risk factor/s:

Relevant family history:

What additional documents have been faxed or sent? e.g. school or allied health reports

RELEVANT INVESTIGATIONS ▸ PLEASE ATTACH COPIES

REFERRING DOCTOR DETAILS

Name:		**Provider no:**
Practice address:		
Suburb:	**State:**	**Postcode:**
Phone:	**Fax:**	
Patient's usual GP (if different from referrer)**:**		
Is anyone else involved in the care of the patient?		**Doctor's signature:**

DO NOT WRITE IN THIS BINDING MARGIN ▸