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Central Referral Hub
Metro South Health Referral Form

PO Box 4195, Eight Mile Plains, QLD 4113
Phone: 1300 364 155 **Fax**: 1300 364 248

Please include ALL standard, essential referral information from: https://metrosouth.health.qld.gov.au/referrals

Referrals are to be sent via secure electronic transfer to -
Medical Objects: MSH Central Referral Hub (MQ4113000HC)
HealthLink: qldmshrh

Preferred method for referrals is GP Smart Referrals **Referral date:**

*NOTE: Kiteworks is for urgent referrals with attachments that can't be sent via secure messaging or fax

PATIENT DETAILS

Full name: **DOB**:

Preferred name: **Gender:**

Street address:

Suburb: **State**: QLD **Postcode:**

Home Phone: **Mobile:**

IHI:

Medicare No.: **Expiry**:

DVA No.: **Card Type:**

Name of parent or caregiver (if applicable):

Relationship of parent or caregiver (if applicable):

Contact number of parent or caregiver (if applicable):

Preferred language:

Interpreter required:

Ethnicity:

ATSI status:

Country of birth:

Compensable status:

Other compensable status:

More information about compensable status at: http://meteor.aihw.gov.au/content/index.phtml/itemId/269397

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REFERRAL DETAILS

Referral Type:

Referral Priority:

Referral Length: 12 months

Specialty Referred To:

Clinical Condition: (e.g. PR bleeding)

Reason for referral/presenting condition: (e.g. abdominal pain - coeliac, polyp surveillance)
Please include ALL standard, essential referral information from: https://metrosouth.health.qld.gov.au/referrals

Choice to be treated as public or private patient:

Choice of consultant referred to as private patient:
View list of specialists at: https://metrosouth.health.qld.gov.au/referrals/specialists

Clinical modifier(s) that may impact patient priority:
Impact on employment; education; home; activities of daily living (low/medium/high); ability to care for others; personal frailty or safety

Does the patient want telehealth consultation:

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MEDICAL HISTORY

Medical History:

Current Medication:

Alerts:

Smoking & Alcohol History:

Family History:

REFERRING CLINICIAN DETAILS

Name:

Provider No:

Practice:

Address:

Phone: **Fax:**

Any other practitioner involved in care of the patient:

Patient's Usual GP (if different from referrer):

VERIFICATION

Electronically Signed:

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Observations and Investigations

Copy and paste from patient's clinical records or attach separately with referral