WHCOR29

Western Health

Aboriginal & Torres Strait Islander Outpatient Clinic Referral Form

Please complete and email to:
AboriginalAndTorresStraitIslanderClinic@wh.org.au

Please complete form digitally and send as attachment

Hospital UR:
Name:
Address:
Suburb and post code:
Telephone:
DOB:

Triage Use Only **Referral date:** Click here to enter a date. **Triaged by:** Choose an item. Click here to enter a date.

Diagnosis/Main health condition: Click here to enter text. **Other factors Affecting Health:** Click here to enter text.

Referrers Name: **Position:** **Tel:**
Referrers Email Address:
Referring Hospital / Agency / Clinic:

GP Name: **Clinic Name:** **Address:**
Tel: **Fax:**

Contact Person/Next of Kin:
Tel:
Mobile:
Address:

NOK Relationship
Female NOK: **Male NOK:**
Contact Person for Appointments:

Case Manager (if Relevant): **Tel:**
Agency/Company Name:

Interpreter Required ☐ Yes ☐ No **Language:**

Patient or carer/NOK must consent to referral
Has the patient consented to this referral: ☐Yes ☐No

Must identify as Aboriginal and/or Torres Strait Islander and over 18 years of age

☐ *Referral for General Medicine review to optimize management for non-acute chronic health conditions.*

If you require an Adult Specialist Clinics review, please refer to: Referralmanagement.Asc@wh.org.au or phone 8345 7733

Presenting problems/issues:

Relevant Medical/Surgical History (or attach current medical history):

Current medications (or attach current medication list):

Social History:

Any special requirements:
Mobility issues ☐ Cognitive issues ☐ Bariatric ☐ Hearing/Visual Deficit ☐
Other- please describe in detail: