



Echuca Regional Health

Surname_____UR NO:_____

Given Name: _____

DOB:_____SEX_____Ward_____

Address:_____

Referral Date:

Specialists Outpatient Clinics Referral Use Label If Available

Email all referrals: consulting_suites@erh.org.au Outpatient enquiries: ph 03 54855 864

Clinic requested

Specialty:

Reason for patient referral / Presenting problem (or working diagnosis)

Referring Doctor Details

Referring Doctor:		Provider number:	
Practice Name:			
Practice Address:			
Suburb:			
Postcode:		Phone No:	
Email:		Fax:	

Patient's usual GP (if not the same as referring doctor)

Clinical information

Gravida / Para :

Last Cervical Screen:

Allergies:

Height (cm):

Weight (kg):

BMI:

Relevant investigation / test results

Please attach results as per the Statewide Referral Criteria for Specialist Clinics <https://src.health.vic.gov.au>

If the required investigation/test results are not attached the referral will not be accepted by ERH

Current medication

Drug name	Ltd. elapse	Strength	Dose / frequency / special

Past medical history

Relevant social history

Other notes *(eg management to date, current services, impact of the problem on the patient)*

Doctor's signature:

Date:

Appointment details will be sent to referring GP and the patient.

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This form constitutes a valid referral to the Echuca Regional Health provided all requested details are complete.