Echuca Regional Health

Referral Date:

Surname_____UR NO:_____
Given Name: _____
DOB:_____SEX_____Ward_____
Address:_____

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.