

 Medical Consulting Suites Building E 25 Francis Street, Echuca Vic 3564 Phone: 03 5485 5864 Fax: 03 5485 5885 Email: consulting_suites@erh.org.au	ERH UR: Name: _____ DOB: _____ Address: _____ Phone: _____ Sex: _____
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Referrals: Outpatient enquiries: +61 3 5485 5864 Fax: +61 5485 5885
 Please email all referrals to: consulting_suites@erh.org.au or consultingrooms@erh.org.au

Referral Date:
Clinic Specialty: Please choose
Practitioner's name (if known):
Clinic Information: specialist-clinics
Note: All Private Clinics need Named Referrals and fees apply

Referring Clinician:

Referring Dr Name:	Provider No:
Practice Name:	
Practice Address: (please include team/ Consultant if patient is an inpatient)	
Phone Number:	
Referrer Signature: :	Referral Date:

Patient Details:

Name:	ERH UR:
Address:	DOB:
	Medicare:
Phone: Please advise of phone number so we can contact the patient	Email:
Carer Name (if applicable):	Carer's phone:
Is the patient Aboriginal and/or Torres Strait Islander?	Yes ☐ No ☐

Consent to referral and sharing of information: Yes ☐ No ☐

GP Details (if referrer is not the patient's usual GP):

Dr Name:	Phone
Practice Name:	Fax:
Practice Address:	

**Phone:**

Sex:

Telehealth consultation request: Yes ☐ No ☐

Referral details (presenting problem and current management):

Statewide referral criteria

Discharge summary attached: ☐ yes ☐ no

Additional Details (including social history, current treatment, past medical history and current services)

Past medical history and current treatment and services

Social history:

Alerts:

 Echuca Regional Health 226 Service Street Echuca VIC 3564 Phone 03 5485 5000 Fax 03 5482 5478 www.erh.org.au ABN 30 490 690 530	ERH UR: Name: DOB: Address: Phone: Sex:
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Current Medications: (please include strength, dose and frequency)

Allergies:

Investigations/ Test Results: Investigations results attached ☐ yes ☐ no

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Referring Doctor Signature:	Referral Date:
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