



REFERRAL FORM

Outpatient Department Use Only:

Clinic: _____

Date & Time: _____

Campus Required:

- Angliss Hospital OPD – Allied Health Only
- Box Hill Hospital
- Maroondah Hospital

Outpatient Department (OPD)

Ph: 9764 6150 Fax: 9764 6149
 Ph: 9895 3353 Fax: 9895 4852
 Ph: 9871 3370 Fax: 9871 3202

Emergency Department (ED)

Nurse: 9764 6246 Doctor: 9759 1983
 Nurse: 9895 3219 Doctor: 9895 3195
 Nurse: 9871 3563 Doctor: 9871 3562

Visit www.easternhealth.org.au to view outpatient services available, current expected waiting time for appointment and consultants in attendance.

Date: _____ Page: _____ of _____

Department Required:

Emergency

Please call ahead to notify

Outpatient:

Specialty: _____

Consultant: _____

Timeframe: Urgent (1-2 weeks) Intermediate (>4 weeks) Routine

If urgent state why: _____

Referral Duration: _____

Patient Details:

Full Name: _____ Male/Female

DOB: _____ Age: _____

Address: _____ Post Code: _____

AH Phone: _____ BH Phone: _____

Email: _____ Mobile: _____

Medicare #: _____ Health Insurance: Yes / No _____

Interpreter: Yes/No Language Required: _____

Reason for Referral: _____

Current Management: _____

Current Medications: _____

Allergies: _____

Relevant Patient History: _____

Referred By:

Name: _____ Provider #: _____

Phone #: _____ Fax #: _____

Email: _____

Clinic Name: _____

Address: _____

_____ Post Code: _____

Signature: _____

Practice Stamp