



Outpatient Clinical Referral

(Affix identification label here)

URN:
 Family name:
 Given name(s):
 Address:
 Date of birth: Sex: M F I

Facility:

ILLEGIBLE REFERRALS WILL BE RETURNED TO THE REFERRER

FAX TO: 4226 8100

For Community Health referrals - see referral guidelines/forms for service area

Date of Request:/...../..... Urgent (<30 days) Associated Care Post Discharge Review
 Timeframe:
 Overbook? Yes No

****If not Urgent, Associated Care, or Post Discharge Review, referral needs to be sent by the GP***

*****Associated care: Includes pre-op reviews/clearance or requests for assessment, investigations or diagnostic tests from one specialist to another within the same hospital for which the outcome is required to inform or progress treatment planning for the same reason for referral.***

Duration: 3 months Other

Is the client of Aboriginal or Torres Strait Islander origin? (for clients of both Aboriginal and Torres Strait Islander origin, tick both 'Yes')

Yes, Aboriginal Yes, Torres Strait Islander No Unknown / Not Stated

Interpreter Required? No Yes If yes, language:

Best Contact Number: Contact person (if different to patient)

Funding Source: DVA Workers Comp Motor Accident Ineligible Indigenous Other

Patient's Nominated General Practitioner – Name and Address:

BULKBILL CLINICS: Refer to a Specialty by selecting a Head of Clinic from the list below.
 Referrals are shared with other Specialists in the clinic to ensure patients are seen as quickly as possible.
 *Specialties with Clinical Prioritisation Criteria (CPC) see <https://cpc.health.qld.gov.au/>. Non-CPC compliant referrals will be returned.



Aged Care/Memory Clinic <input type="checkbox"/> Dr Eddy Strivens *Cardiology <input type="checkbox"/> Dr Greg Stamer Dermatology <input type="checkbox"/> Dr Ilsphe Browne *Diabetes <input type="checkbox"/> Dr Ashim Sinha *Endocrinology <input type="checkbox"/> Dr Ashim Sinha *Endoscopy <input type="checkbox"/> Dr Peter Boyd *ENT <input type="checkbox"/> Dr Edmund Kennedy *Gastroenterology <input type="checkbox"/> Dr Peter Boyd *General Medicine <input type="checkbox"/> Dr Ben Vogler	Haematology <input type="checkbox"/> Dr Andrew Shearer Hepatology <input type="checkbox"/> Dr Peter Boyd Infectious Disease <input type="checkbox"/> Dr Enzo Binotto Immunology <input type="checkbox"/> Dr Peter Bourke *Medical Oncology <input type="checkbox"/> Dr Megan Lyle *Nephrology <input type="checkbox"/> Dr Murty Mantha *Neurology <input type="checkbox"/> Dr Ian Wilson Obstetric Medicine <input type="checkbox"/> Dr Nirjhar Nandi *Obstetrics/ Gynaecology <input type="checkbox"/> Dr Samantha Scherman	*Ophthalmology <input type="checkbox"/> Dr Stephen O'Hagan *Orthopaedics <input type="checkbox"/> Dr Arvind Puri *Paediatrics <input type="checkbox"/> Dr Neil Archer Palliative Care <input type="checkbox"/> Dr Edward Mantle *Radiation Oncology <input type="checkbox"/> Dr Lisa Capelle Rehabilitation <input type="checkbox"/> Dr Wei Qu Rheumatology <input type="checkbox"/> Dr Zia-Ur Rehman *Surgical - General <input type="checkbox"/> Dr Roxanne Wu *Surgical - Breast <input type="checkbox"/> Dr Timothy Elston	*Surgical - Plastics <input type="checkbox"/> Dr Jaime Zwart *Surgical - Vascular <input type="checkbox"/> Dr Sherab Bhutia Stroke <input type="checkbox"/> or TIA <input type="checkbox"/> <input type="checkbox"/> Dr Ramesh Durairaj *Thoracic/ Respiratory <input type="checkbox"/> Dr Stephen Vincent *Urology <input type="checkbox"/> Dr Philip Smith *Urogynaecology <input type="checkbox"/> Dr Carol Breeze <input type="checkbox"/> Other SMO
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PUBLIC CLINIC and referrals from the Emergency Department

Clinic Name/ Specialty:

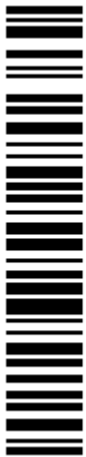
OTHER HEALTH SERVICES **Refer to additional diagnostic form for completion (MR51A)*

<input type="checkbox"/> Cardiac Investigations*	<input type="checkbox"/> Neurodiagnostic*	<input type="checkbox"/> Nutrition & Dietetics
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physiotherapy	<input type="checkbox"/> Psychology / Neuropsychology
<input type="checkbox"/> Respiratory / Sleep*	<input type="checkbox"/> Social Work	<input type="checkbox"/> Speech Pathology
<input type="checkbox"/> Continence Clinic	<input type="checkbox"/> Orthotics & Surgical Footwear	<input type="checkbox"/> Podiatry (Innisfail/Babinda/Mossman)

Please complete both sides of this form

DO NOT WRITE IN THIS BINDING MARGIN

Do not reproduce by photocopying
All clinical form creation and amendments must be conducted through Health Information Services



DD214:51

OUTPATIENT CLINICAL REFERRAL

MR51

