Queensland Government

Outpatient Clinical Referral

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

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.*

Clinical Prioritisati...

Aged Care/Memory Clinic
☐ Dr Eddy Strivens

***Cardiology**
☐ Dr Greg Starmer

Dermatology
☐ Dr Ilsphi Browne

***Diabetes**
☐ Dr Ashim Sinha

***Endocrinology**
☐ Dr Ashim Sinha

***Endoscopy**
☐ Dr Peter Boyd

***ENT**
☐ Dr Edmund Kennedy

***Gastroenterology**
☐ Dr Peter Boyd

***General Medicine**
☐ Dr Ben Vogler

Haematology
☐ Dr Andrew Shearer

Hepatology
☐ Dr Peter Boyd

Infectious Disease
☐ Dr Enzo Binotto

Immunology
☐ Dr Peter Bourke

***Medical Oncology**
☐ Dr Megan Lyle

***Nephrology**
☐ Dr Murty Mantha

***Neurology**
☐ Dr Ian Wilson

Obstetric Medicine
☐ Dr Nirjhar Nandi

***Obstetrics/ Gynaecology**
☐ Dr Samantha Scherman

***Ophthalmology**
☐ Dr Stephen O'Hagan

***Orthopaedics**
☐ Dr Arvind Puri

***Paediatrics**
☐ Dr Neil Archer

Palliative Care
☐ Dr Edward Mantle

***Radiation Oncology**
☐ Dr Lisa Capelle

Rehabilitation
☐ Dr Wei Qu

Rheumatology
☐ Dr Zia-Ur Rehman

***Surgical - General**
☐ Dr Roxanne Wu

***Surgical - Breast**
☐ Dr Timothy Elston

***Surgical - Plastics**
☐ Dr Jaime Zwart

***Surgical - Vascular**
☐ Dr Sherab Bhutia

Stroke ☐ **or TIA** ☐
☐ Dr Ramesh Durairaj

***Thoracic/ Respiratory**
☐ Dr Stephen Vincent

***Urology**
☐ Dr Philip Smith

***Urogynaecology**
☐ Dr Carol Breeze

☐ **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)*

☐ Cardiac Investigations*	☐ Neurodiagnostic*	☐ Nutrition & Dietetics
☐ Occupational Therapy	☐ Physiotherapy	☐ Psychology / Neuropsychology
☐ Respiratory / Sleep*	☐ Social Work	☐ Speech Pathology
☐ Continence Clinic	☐ Orthotics & Surgical Footwear	☐ Podiatry (Innisfail/Babinda/Mossman)

Please complete both sides of this form

OUTPATIENT CLINICAL REFERRAL MR51

Queensland Government

Outpatient Clinical Referral

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Reason for Referral: .....

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Provisional Clinical Diagnosis: .....

Significant Background / Active Problems: .....

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Allergies / Adverse Reactions: .....

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Current Medications: .....

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Pacemaker: ☐ Yes ☐ No

Anti-coagulation meds: .....

Anti-epileptic: .....

Anti-psychotic: .....

Sedatives: .....

Investigations or Assessments Undertaken / Results: Additional information attached: ☐ Yes ☐ No

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Suggested Action / Request: .....

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From: ☐ Inpatient Ward ..... ☐ Community Health .....

☐ Outpatient Clinic ..... ☐ Other Service .....

☐ Emergency Department ..... ☐ Facility Name .....

Name: ..... **Signature:** .....

Designation: ..... **Contact Number:** .....

Provider Number: ..... **Specialty:** .....

Referring Consultant: ..... **Are you referring as a GP?** ☐ Yes ☐ No

Please complete both sides of this form