

Surname:

UR no:

Given name/s:

Date of birth:

Sex:

Referral date:

Address:

Women's Health Clinic - Referral form

Reason for referral / presenting problem

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Referring doctor details

Referring doctor:		Provider number:	
Practice name:			
Practice address:			
Postcode:		Phone no.	
Email:		Fax:	
Patient's usual GP (if not the same as referring doctor):			

Relevant 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>

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Current medication

Drug name	Strength	Dose / frequency / special

Past medical history

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Relevant social history

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Other notes

(For example, management to date, current services, impact of the problem on the patient)

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Doctor's signature:**Date:**

Email all referrals: intake@castlemainehealth.org.au