West Moreton Health Central Referrals Hub
SPECIALIST OUTPATIENT REFERRAL FORM
Ipswich Hospital Outpatient Department (IQ43050005G)

Urgent Fax line 3413 7277 Routine Fax 3810 1438

If patient has been transferred to the Emergency Department and additional information has been requested, please fax information directly to the Emergency Department on 3810 1764

General information about referrals

For further information regarding Clinical Prioritisation Criteria (CPC) and Referral Guidelines for medical conditions suitable for referral to WMH Specialist Outpatient Clinics please visit:
https://westmoreton.communityhealthpathways.org/ ***or*** https://www.westmoreton.health.qld.gov.au/refer
CPC and Guidelines also include information about specific conditions that should be considered 'emergency referrals' and be sent directly to the Emergency Department and those that are considered 'out-of-scope' for public outpatient services.

Referral Information

Urgency of referral:

Referral Date: Length of referral?:

Referral Type:

Reason for Triage Upgrade request:

Speciality Referred to:

Is this a named referral?:

Reason for Referral (clinical condition e.g. Chest Pain):

Have all essential referral criteria (CPC) requirements been addressed?

Reason for Clinical override?

Presence of Clinical Modifier(s)? (copy and paste all that apply)
Impact on employment; education; home; activities of daily living (low/medium/high); ability to care for others; personal frailty or safety

Please type all further information regarding referral and clinical override here:
Please include ALL standard, essential referral information from https://www.westmoreton.health.qld.gov.au/refer

Other referral information

Is your practice enabled to support a clinically appropriate Telehealth Appointment? (if applicable)

Could Case conference be considered for Complex and Palliative Chronic disease patients?

Patient Details ***Next of kin must be completed for children under the age of 18***

Full name: Date of Birth: Age:

Preferred Name: Gender:

Street Address:

Suburb: State: Postcode:

Postal Address:

Phone (Home): Phone (Work): Phone (Mobile):

IHI:

Medicare Number: Medicare Line number: Medicare expiry:

DVA Number: Card Type:

Pension number:

Private Health Insurance fund: Fund number:

Aboriginal and Torres Strait Islander status:

Ethnicity: Is the patient of refugee background?

If yes, please provide relevant details:

Interpreter Required: Preferred Language:

Next of Kin name: Next of Kin Phone: Next of Kin Relationship:

If the client is a paediatric patient, are they under the care of the Department of Child Safety?

Caseworker Details (if applicable):

Does patient consent to email or SMS Contact from West Moreton Health?

Current and Past Clinical History

History of Current Conditions:

Current Medication List:

Allergies/Adverse Events:

Smoking Status:

Alcohol Consumption:

Relevant Social History:

Relevant Family History:

Observations

Height:

Weight:

BMI:

Referring Doctor Details

Doctor: Provider No:

Practice Name: Practice HPI-O:

Doctor Address:

Phone:

Fax:

Email:

Are any other practitioner involved in care of the patient?

Patient's Usual GP (if different from referrer):

Electronic Verification and Signature

Date:

Recent Investigations and Patient notes:

Copy and paste from patient's clinical records or attach separately with referral

Print Save form Reset form