



# REFERRAL TO MATER ADULTS SPECIALIST CLINICS

MHS Unit Record No. \_\_\_\_\_

Surname \_\_\_\_\_

Given Names \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

To ensure a timely appointment, complete all sections of this form. Incomplete forms will be returned for completion.

Residential Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_ Mobile Phone No.: \_\_\_\_\_

Medicare Eligible:  Yes  No Medicare No.: \_\_\_\_\_ Card Ref. No.: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Private Health Insurance:  Yes  No Interpreter Required:  Yes  No Language: \_\_\_\_\_

Compensable Status:  3rd Party Insurance  Personal Injury  Workcover Qld  DVA  Other, specify: \_\_\_\_\_

## Patient Referral Options

- Please select  **ONE** specialist, from the list below, you wish to refer your patient to.
- To improve efficiency and reduce waiting times, this named referral may be shared with other specialists.
- The Outpatient Consultation cost may be bulk-billed to Medicare Australia, with **NO** out-of-pocket expenses for this patient.
- If your patient wishes to be seen as a Public patient **ONLY** (i.e. **not bulk billed**) then please indicate here .

Referral Details I have discussed the options for care with my patient and elect the following:

### Breast/Endocrine Surgery

- Dr C Pyke
- Dr C Allan
- Dr J Lambley

### Cardiology

- Dr P Palka
- Dr K Kostner
- Dr S Prasad

### Colorectal Surgery

- Dr J Dale
- Dr C Chow

### Dermatology

- Dr J Muir
- Dr A Herat
- Dr A Mullholland

### Endocrine / Diabetes

- Dr A Morton
- Dr N D'Silva
- Dr T O'Moore-Sullivan

### ENT

- Dr A Parker
- Dr J Askew
- Dr R Black
- Dr S Coman
- Dr C Que Hee
- Dr N Slee

### Fracture Clinic

- Dr J Radovanovic
- Dr D Bade

### Gastroenterology

- Dr J Wittmann
- Dr L Chang
- Dr M Haque
- Dr T Florin
- Dr M Mortimore
- Dr S Vigh

### General Medical

- Dr M King

### General Surgical

- Dr M Carmody
- Dr S Naidu

### Gynaecology

- Dr M Beckmann
- Dr E Bolton
- Dr R Butler
- Dr D Cave
- Dr P Conaghan
- Dr T Jacobsen
- Dr M Wynn Williams
- Dr D Poad
- Dr H Tang
- Dr P Higgs

### Gynae/Oncology

- Dr L Perrin
- Dr N Chetti
- Dr A Crandon

### Haematology

- Dr L Catley
- Dr R Banh

### Infectious Diseases

- Dr J McCormack

### Maxillofacial Surgery

- Dr B Erzetic

### Nephrology

- Dr J Burke

### Neurology

- Dr C Staples

### Oncology

- Dr C Shannon
- Dr M Atkinson
- Dr M Colosimo
- Dr Z Lwin
- Dr N Woodward

### Ophthalmology

- Dr A Kwan
- Dr R Kempster
- Dr J McAlister
- Dr J McCoombes
- Dr M McGree
- Dr L Ooi
- Dr D Posselt
- Dr R Thomas
- Dr P Vu

### Orthopaedic

- Dr S Journeaux
- Dr D Bade
- Dr J Walsh
- Dr I Astori
- Dr B Forster
- Dr P McMeniman
- Dr P Myers
- Dr J Peereboom
- Dr J Radovanovic

### Palliative Care

- Dr J Hardy

### Respiratory

- Dr S Bowler
- Dr K Semple
- Dr D Serisier

### Rheumatology

- Dr J O'Callaghan

### Urology

- Dr S Philip
- Dr A Clubb
- Dr P Swindle
- Dr R Watson
- Dr D Winkle

### Minor Skin Lesion

- Dr C Rogers

### Vascular Surgery

- Dr J Bingley
- Dr P Bryant

Updated Referral:

Yes  No

Date of Referral:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Duration of Referral:

- 3 months
- 12 months
- Indefinite

**FAX COMPLETED  
FORM TO MATER AT  
(07) 3163 8548**

REFERRAL TO MATER ADULTS SPECIALIST CLINICS 203

## Referring Clinician to complete all fields clearly

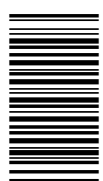
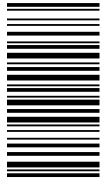
Referring Clinician Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Practice Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_\_ Fax Number: \_\_\_\_\_

\_\_\_\_\_ Email: \_\_\_\_\_



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**REFERRAL TO MATER ADULTS  
SPECIALIST CLINICS**

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Surname \_\_\_\_\_

Given Names \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

**Reason for Referral:** *Include or attach any relevant supporting information to assist appropriate triage*

Provisional Diagnosis/Presenting Condition: .....

Relevant Clinical History/Examination: .....

**Manipulation:**  Yes  No    **Sedation/LA/GA:**  Yes  No

**Allergies:** .....

**Relevant Investigations:**

**Medications:**

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Referring Clinician Name: .....

Signature: ..... Date: .....

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