



REFERRAL TO MATER CHILDREN'S 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:

Cardiac Surgery <input type="checkbox"/> Dr T Karl <input type="checkbox"/> Dr S Provenzano Cardiology <input type="checkbox"/> Dr R Justo <input type="checkbox"/> Dr B Anderson <input type="checkbox"/> Dr S Fox <input type="checkbox"/> Dr A Gooi <input type="checkbox"/> Dr J Morwood <input type="checkbox"/> Dr C Ward Childhood Hearing <input type="checkbox"/> Dr K Liddle Dermatology <input type="checkbox"/> Dr CT Lee Endocrine / Diabetes <input type="checkbox"/> Dr A Cotterill <input type="checkbox"/> Dr M Harris <input type="checkbox"/> Dr G Leong ENT <input type="checkbox"/> Dr A Parker <input type="checkbox"/> Dr J Askew <input type="checkbox"/> Dr R Black <input type="checkbox"/> Dr H Burns <input type="checkbox"/> Dr B Panizza <input type="checkbox"/> Dr C Que Hee <input type="checkbox"/> Dr N Slee Fracture Clinic <input type="checkbox"/> Dr D Bade Gastroenterology <input type="checkbox"/> Dr G Withers <input type="checkbox"/> Dr E McIntyre	General Medical <input type="checkbox"/> Dr D McCrossin <input type="checkbox"/> Dr B Anderson <input type="checkbox"/> Dr J Beak <input type="checkbox"/> Dr M Boyd <input type="checkbox"/> Dr R Brown <input type="checkbox"/> Dr A Cohn <input type="checkbox"/> Dr J Connors <input type="checkbox"/> Dr R James <input type="checkbox"/> Dr D Levitt <input type="checkbox"/> Dr J Mellick <input type="checkbox"/> Dr I Robertson <input type="checkbox"/> Dr D True General Surgical <input type="checkbox"/> Dr B Patel <input type="checkbox"/> Dr P Borzi <input type="checkbox"/> Dr C Bourke <input type="checkbox"/> Dr K Choo <input type="checkbox"/> Dr R Das Gupta <input type="checkbox"/> Dr R Kimble <input type="checkbox"/> Dr C McBride Genetics <input type="checkbox"/> Dr A Zankl <input type="checkbox"/> Dr J McGaughran Haematology <input type="checkbox"/> Dr P Wilson <input type="checkbox"/> Dr J Robertson Infectious Diseases <input type="checkbox"/> Dr C Nourse <input type="checkbox"/> Dr V Vaska Metabolic <input type="checkbox"/> Dr F Bowling	Nephrology <input type="checkbox"/> Dr J Burke <input type="checkbox"/> Dr S McTaggart <input type="checkbox"/> Dr P Trnka Neurodevelopmental/ Autism <input type="checkbox"/> Dr H Heussler <input type="checkbox"/> Dr A Leslie <input type="checkbox"/> Dr T Marsh <input type="checkbox"/> Dr U Tran Neurology <input type="checkbox"/> Dr G Wallace <input type="checkbox"/> Dr C Burke <input type="checkbox"/> Dr A Cairns <input type="checkbox"/> Dr S Calvert <input type="checkbox"/> Dr K Riney Neurosurgery <input type="checkbox"/> Dr R Campbell <input type="checkbox"/> Dr M Wood Ophthalmology <input type="checkbox"/> Dr M Forrest <input type="checkbox"/> Dr R Kempster <input type="checkbox"/> Dr A Kleinschmidt <input type="checkbox"/> Dr A Kwan <input type="checkbox"/> Dr J McAlister <input type="checkbox"/> Dr J McCoombes <input type="checkbox"/> Dr M McGree <input type="checkbox"/> Dr L Ooi <input type="checkbox"/> Dr D Posselt <input type="checkbox"/> Dr R Thomas <input type="checkbox"/> Dr P Vu	Orthopaedic <input type="checkbox"/> Dr J Walsh <input type="checkbox"/> Dr I Astori <input type="checkbox"/> Dr J Bartlett <input type="checkbox"/> Dr J Radovanovic <input type="checkbox"/> Dr J Scott Plagiocephaly <input type="checkbox"/> Dr R Lewandowski Plastic/Reconstructive <input type="checkbox"/> Dr R Lewandowski <input type="checkbox"/> Dr S Bade <input type="checkbox"/> Dr S Ingram <input type="checkbox"/> Dr S O'Mahoney <input type="checkbox"/> Dr R Thiele Respiratory <input type="checkbox"/> Dr M-A Harris <input type="checkbox"/> Dr S Burgess <input type="checkbox"/> Dr C Dakin <input type="checkbox"/> Dr L Gauld <input type="checkbox"/> Dr S Suresh Rheumatology <input type="checkbox"/> Dr N Adib Sleep Medicine <input type="checkbox"/> Dr M-A Harris <input type="checkbox"/> Dr S Burgess <input type="checkbox"/> Dr C Dakin <input type="checkbox"/> Dr L Gauld <input type="checkbox"/> Dr H Heussler <input type="checkbox"/> Dr S Suresh	Spinal / Orthopaedic Surgery <input type="checkbox"/> Dr G Askin <input type="checkbox"/> Dr J Albietz <input type="checkbox"/> Dr S Gatehouse <input type="checkbox"/> Dr R Labrom <input type="checkbox"/> Dr P Licina <input type="checkbox"/> Dr W Ryan <input type="checkbox"/> Dr J Tuffley Urology <input type="checkbox"/> Dr P Borzi <input type="checkbox"/> Dr D Winkle
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Updated Referral:
 Yes No

Date of Referral:
 _____ / _____ / _____

Duration of Referral:
 3 months
 12 months
 Indefinite

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

Referring Clinician to complete all fields clearly

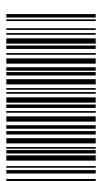
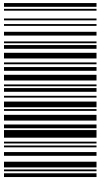
Referring Clinician Name: _____

Signature: _____ Provider Number: _____

Practice Address: _____ Phone Number: _____

_____ Fax Number: _____

_____ Email: _____



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Binding margin - do not write.



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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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