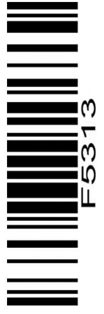
REFERRAL TO MATER OUTPATIENT CLINICS (for patients aged 16 and over)

Unit Record No. ______
Surname ______
Given Names ______
DOB ______ Sex ______
AFFIX PATIENT IDENTIFICATION LABEL HERE



F5313

Binding margin - do not write. Do not reproduce by photocopying.
All clinical form creation and amendments must be conducted through Health Records.

Surname:	Given name(s):
Date of birth:	Sex: ☐ Female ☐ Male
Parent/Guardian full name *(if applicable)*:	
Address:	
Suburb:	State: / Postal code:
Home phone:	Mobile phone:

Medicare eligible? ☐ Yes ☐ No If YES, Medicare number: ...... Reference: ...... Expiry date: ......

Interpreter required? ☐ Yes ☐ No If YES, language: ......

Is the patient of refugee background? ☐ Yes ☐ No | Is the patient living at a Residential Aged Care Facility? ☐ Yes ☐ No

Is the patient of Aboriginal or Torres Strait Islander origin?
☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Declined to answer

Private health insurance? ☐ Yes ☐ No | NDIS participant? ☐ Yes ☐ No If YES, NDIS number: ......

Compensable status? ☐ 3rd Party ☐ Personal injury ☐ WorkCover Qld ☐ DVA ☐ Other *(specify)*: ......

Reason for Referral

Please include essential condition-specific information outlined in standard referral guidelines, located at www.materonline.org.au

Provisional diagnosis/resenting condition/what question(s) are you asking of your specialist colleagues:

Relevant clinical history/examination:

My patient's condition corresponds with the following urgency category and associated clinically recommended waiting time as per referral criteria www.materonline.org.au:

Category: ☐ **1** ☐ **2** ☐ **3**

Allergies

Name of medication/food/other	Description of previous reaction	Name of medication/food/other	Description of previous reaction

Relevant Investigations

What investigations have you undertaken? Please attach PDF copies of all relevant results.

Medications

Medication name	Strength	Dose	Medication name	Strength	Dose

REFERRAL TO MATER OUTPATIENT CLINICS

11/21
Ver. 3.00
F5313

© Copyright Mater Misericordiae Limited. All rights reserved.

mater health

REFERRAL TO MATER OUTPATIENT CLINICS (for patients aged 16 and over)

Unit Record No. ____________________

Surname ____________________

Given Names ____________________

DOB ____________ Sex ____________

AFFIX PATIENT IDENTIFICATION LABEL HERE

Specialty Details

Referrals are shared with other specialists in the clinic to ensure patients are seen as quickly as possible.

Please select head of clinic from the list below.

Specialty	Head of clinic	Specialty	Head of clinic
Breast/Endocrine	☐ Dr J Lambley	**Maxillofacial Surgery**	☐ Dr M Burgess
Cardiology	☐ Dr K Kostner	**Memory and Cognitive Disorders**	☐ Dr P Nestor
Colorectal Surgery	☐ Dr J Lambley	**Metabolic Disorders**	☐ Dr J Nisbet
Dermatology	☐ Dr J Muir	**Nephrology**	☐ Dr M Burke
Diabetes/Endocrine	☐ Dr H Barrett	**Neurology**	☐ Dr C O'Gorman
Ear, Nose and Throat (ENT)	☐ Dr J Askew	**Neurosurgery**	☐ Dr A Tsahtsarlis
Epilepsy	☐ Dr C O'Gorman	**Oncology**	☐ Dr V Jain
Fracture	☐ Dr J Radovanovic	**Ophthalmology**	☐ Dr S Warrier
Gastroenterology	☐ Dr J Begun	**Orthopaedic**	☐ Dr J Radovanovic
General Medicine	☐ Dr C Corney	**Palliative Care**	☐ Dr J Hardy
General Surgery	☐ Dr J Lambley	**Plastic Surgery**	☐ Dr B Louie
Gynaecology	☐ Dr S Janssens	**Respiratory**	☐ Dr L Burr
Gynaecology Oncology	☐ Dr L Perrin	**Rheumatology**	☐ Dr J O'Callaghan
Haematology	☐ Dr N Gutta	**Urology**	☐ Dr R Watson
Infectious Diseases	☐ Dr P Griffin	**Vascular Surgery**	☐ Dr J Bingley
Intellectual Disability and Autism	☐ Dr C Franklin	**Other services**	☐ Mater Refugee Complex Care

Referral Period

Continuation referral? ☐ Yes ☐ No

Updated referral/Additional information? ☐ Yes ☐ No

Duration of referral: ☐ 3 months (standard referral from specialist) ☐ 12 months (standard referral from GP)
☐ Indefinite (chronic conditions only

Telehealth

This patient may be suitable for a telehealth consultation? ☐ Yes ☐ No

Is the referring practitioner to be involved in the telehealth consultation? ☐ Yes ☐ No

Referring Clinician Details (please complete all fields clearly)

Date of referral:	Provider number:
Referring clinician name:	
Practice address:	
Phone number:	Fax number:
Email address:	
Referring clinician signature:	

Referrals can be sent by:

Secure messaging Medical Objects: **HM4101000R8**

HealthLink EDI: **materref**

Fax number: **07 3163 8548**

Binding margin - do not write. Do not reproduce by photocopying.
All clinical form creation and amendments must be conducted through Health Records.

© Copyright Mater Misericordiae Limited. All rights reserved.