WOMEN'S & CHILDREN'S HEALTH

FAST FAX REFERRALS

FAX NUMBER: (03) 9344 2677

To refer a patient to a clinic please complete the following details

Patient's name: ……..

Date of Birth: …….. UR Number (if known): ……..…….

Address: ……..

Telephone: …….

Clinic required:
- ❑ Antenatal EDC ……
- ❑ Gynaecology
- ❑ Dysplasia
- ❑ Other ……..……

Interpreter required: ❑ No ❑ Yes Language:……..…….

Details of condition: (Attach separate sheet if necessary)

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Doctor's Name: ……

Dr's Address……..

Doctor's telephone number:……Fax number:……..……

Outpatients will send appointment details directly to this patient and a confirmatory letter to you