REFERRAL OUTPATIENT CLINIC CHW

Copies available via
https://www.schn.health.nsw.gov.au/hospitals/chw/chw-clinics

Fax to 9845 0566

Email to SCHN-CHW-Outpatients@health.nsw.gov.au

MRN ____________________

NAME ____________________

DOB ____________ **SEX** ________

(PLEASE AFFIX **CHW PATIENT LABEL** IN THIS BOX)

Your patient will receive a letter with the details of their scheduled appointment. For all enquires please telephone 9845 2525

Patient details

Surname:____________________ Given names:____________________

Date of birth:____________________ Sex: Male ☐ Female ☐

Address:____

Preferred contact number: ________________________________

Mobile*____________________Other____________________

Language spoken at home:________________________________

Interpreter required: Yes ☐ No ☐

*** Mobile Number used to send SMS reminder before appointment**

Clinical details - Outpatient consultants and clinic information, available at:

https://www.schn.health.nsw.gov.au/hospitals/chw/chw-clinics

Consultants Name____________________ Clinic required____________________

Reason for referral / diagnosis:________________________________

Relevant past history:________________________________

Please include relevant medications, pathology and imaging results with this referral

Assessment of Priority - □ **≤ 30 days** □ **≥ 30 days** □ **Routine/ Follow-Up**

Referral duration: ☐ **3 months** ☐ **12 months** ☐ **Indefinite** ☐ **Other**____________

Referring doctor details

Surname:____________________ Given name:____________________

Provider number:____________________

Address:____________________

Telephone Number:____________________

Fax number:____________________

Email Address: ____________________

Doctor's signature:____________________

Date____________________

Preferred contact: ☐ Telephone ☐ Fax ☐ Email

Practice stamp

(if available)

THE CHILDREN'S HOSPITAL AT WESTMEAD

1010

REFERRAL OUTPATIENT CLINIC CHW

M2BB