



Perinatal Medicine Referral Form

Mercy Public Hospital Inc - Mercy Hospital for Women

163 Studley Road, Heidelberg Vic 3084 Phone: 03 8458 4248 Fax: 03 8458 4205

Patient Details X where applicable

Previous Mercy Hospital for Women (MHW) patient?		Yes	No						
Full Name:		ATSI:	Not Aboriginal or TSI	Both Aboriginal or TSI	TSI				
Date of Birth:		Eligible for Medicare:		Yes	No				
Address:		Medicare No:		IRN:	Exp. Date:				
Post Code:		Health Insurance Fund:			No.:				
Phone (H):	Mobile:	Disability or special needs:		Yes	No				
Language spoken at home:		Specify:							
Interpreter Required?	Language:								

Referring Doctor

Print name:		Provider no.:		
Practice Name & Address:				
			Postcode:	

Reason for Referral / Diagnosis

Relevant co-morbidities / past medical/surgical/ mental health / genetic / family history:

Medicines & Allergies:

Investigations Ordered: (Please attach all relevant results to assist us to triage correctly)

Doctor's signature: _____ Date: _____

You should receive written notification from us within 8 working days confirming receipt of your referral. Failure to supply all the required information may lead to a delay in your referral being processed as we may need to seek the additional information.

Pages to follow (including cover sheet): _____

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