

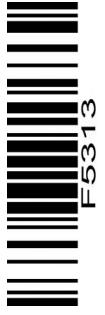
Unit Record No. \_\_\_\_\_

Surname \_\_\_\_\_

Given Names \_\_\_\_\_

DOB \_\_\_\_\_ Sex \_\_\_\_\_

AFFIX PATIENT IDENTIFICATION LABEL HERE



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](http://www.materonline.org.au)

Provisional diagnosis/presenting 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](http://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

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REFERRAL TO MATER OUTPATIENT CLINICS

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.

Head of clinic		Head of clinic	
Breast/Endocrine	<input type="checkbox"/> Dr C Allan	Maxillofacial Surgery	<input type="checkbox"/> Dr M Burgess
Cardiology	<input type="checkbox"/> Dr K Kostner	Memory and Cognitive Disorders	<input type="checkbox"/> Dr P Nestor
Colorectal Surgery	<input type="checkbox"/> Dr C Allan	Metabolic Disorders	<input type="checkbox"/> Dr J Nisbet
Dermatology	<input type="checkbox"/> Dr J Muir	Nephrology	<input type="checkbox"/> Dr M Burke
Diabetes/Endocrine	<input type="checkbox"/> Dr L Phillips	Neurology	<input type="checkbox"/> Dr A Swayne
Ear, Nose and Throat (ENT)	<input type="checkbox"/> Dr A Chang	Neurosurgery	<input type="checkbox"/> Dr A Tsahsarlis
Epilepsy	<input type="checkbox"/> Dr A McGonigal	Oncology	<input type="checkbox"/> Dr V Jain
Fracture	<input type="checkbox"/> Dr J Radovanovic	Ophthalmology	<input type="checkbox"/> Dr S Warrior
Gastroenterology	<input type="checkbox"/> Dr J Begun	Orthopaedic	<input type="checkbox"/> Dr J Radovanovic
General Medicine	<input type="checkbox"/> Dr M Hewitt	Palliative Care	<input type="checkbox"/> Dr P Good
General Surgery	<input type="checkbox"/> Dr C Allan	Plastic Surgery	<input type="checkbox"/> Dr J Allan
Gynaecology	<input type="checkbox"/> Dr S Janssens	Respiratory	<input type="checkbox"/> Dr L Burr
Gynaecology Oncology	<input type="checkbox"/> Dr N Chetty	Rheumatology	<input type="checkbox"/> Dr J O'Callaghan
Haematology	<input type="checkbox"/> Dr N Gutta	Urology	<input type="checkbox"/> Dr R Watson
Infectious Diseases	<input type="checkbox"/> Dr P Griffin	Vascular Surgery	<input type="checkbox"/> Dr D Hagley
Intellectual Disability and Autism	<input type="checkbox"/> Dr C Franklin	Other services	<input type="checkbox"/> 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**

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