F5313

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

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/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:

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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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	☐ Dr C Allan	**Maxillofacial Surgery**	☐ Dr M Burgess
Cardiology	☐ Dr K Kostner	**Memory and Cognitive Disorders**	☐ Dr P Nestor
Colorectal Surgery	☐ Dr C Allan	**Metabolic Disorders**	☐ Dr J Nisbet
Dermatology	☐ Dr J Muir	**Nephrology**	☐ Dr M Burke
Diabetes/Endocrine	☐ Dr L Phillips	**Neurology**	☐ Dr A Swayne
Ear, Nose and Throat (ENT)	☐ Dr A Chang	**Neurosurgery**	☐ Dr A Tsahtsarlis
Epilepsy	☐ Dr A McGonigal	**Oncology**	☐ Dr V Jain
Fracture	☐ Dr J Radovanovic	**Ophthalmology**	☐ Dr S Warrier
Gastroenterology	☐ Dr J Begun	**Orthopaedic**	☐ Dr J Radovanovic
General Medicine	☐ Dr M Hewitt	**Palliative Care**	☐ Dr P Good
General Surgery	☐ Dr C Allan	**Plastic Surgery**	☐ Dr J Allan
Gynaecology	☐ Dr S Janssens	**Respiratory**	☐ Dr L Burr
Gynaecology Oncology	☐ Dr N Chetty	**Rheumatology**	☐ Dr J O'Callaghan
Haematology	☐ Dr N Gutta	**Urology**	☐ Dr R Watson
Infectious Diseases	☐ Dr P Griffin	**Vascular Surgery**	☐ Dr D Hagley
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**

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