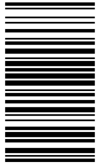
REFERRAL TO MATER ALLIED HEALTH SERVICES

Unit Record No. ____
Surname ____
Given Names ____
Date of Birth ____ Sex Male Female



Binding margin - do not write. Do not reproduce by photocopying.
All clinical form creation and amendments must be conducted through Health Information Services.

To ensure a timely appointment, complete all sections of this form. Incomplete forms will be returned for completion.

Residential address: ....
Suburb: .... State: .... Postal code: ....
Home phone no.: .... Mobile phone no.: ....
Interpreter required: Yes No Language: ....
Is the patient of Aboriginal or Torres Strait Islander origin: Yes, Aboriginal Yes, Torres Strait Islander No Unknown
Medicare eligible: Yes No Medicare no.: .... Card reference no.: .... Expiry date: ....
Private health insurance: Yes No E-mail address: ....
Compensable status: 3rd Party Personal injury Workcover Qld DVA Other, specify: ....

Referral Details Service Required

Urgent referral

Audiology
Mater at Home (DART)
Mater Aged Placement Services (MAPS)
Nutrition and Dietetics

Occupational Therapy:
- Adult Stress Management
- Adult Hands and Rheumatology
- Complex Medical and Development needs

Physiotherapy

Speech Pathology:
- Adult and paediatric feeding and swallowing
- Adult Fluency

Reason for referral: *(Include or attach any relevant supporting information to assist appropriate triage)*

Provisional diagnosis/ Presenting condition: *(Including date of diagnosis)*

....

Relevant clinical history/ Examination:

....

Other relevant information:
Developmental delay? Yes No
Physical impairment? Yes No
Intellectual impairment? Yes No

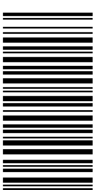
Approximate developmental age: ....
Mobility assistance required? Yes No
Specify: ....
Behaviour/ Socialisation concerns (e.g. Autism)? Yes No

Relevant investigations (include syndromes suspected or under investigation)

....

Any other relevant information: (e.g. current court orders, cultural background information)

....



Referring clinician to complete all fields clearly

Date of referral: .... Provider number: ....
Referring clinician name: ....
Practice address: ....
Phone number: .... E-mail address: ....
Fax number: .... Referring clinician signature: ....

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Ver. 3.0
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