



REFERRAL TO MATER ADULTS SPECIALIST CLINICS

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

Surname \_\_\_\_\_

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

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

AFFIX PATIENT IDENTIFICATION LABEL HERE

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

Compensable status:  3rd Party  Personal injury  Workcover Qld  DVA  Other, specify: \_\_\_\_\_

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

Please check the referral guidelines for this speciality online at [www.materonline.org.au](http://www.materonline.org.au)

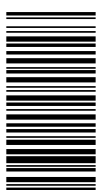
Provisional diagnosis / Presenting condition / What question/s are you asking of your specialist colleagues:

Relevant clinical history / Examination: \_\_\_\_\_

Allergies: \_\_\_\_\_

Relevant investigations: \_\_\_\_\_

Medications: \_\_\_\_\_



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**Referral details**

Please select  a *Head of Clinic* from the list below.

Referrals are shared with other specialists in the clinic to ensure patients are seen as quickly as possible.

**Breast / Endocrine Surgery**

Dr. C. Pyke

**Cardiology**

Dr. P. Palka

**Colorectal Surgery**

Dr. J. Dale

**Dermatology**

Dr. J. Muir

**Endocrine / Diabetes**

Dr. T. O'Moore-Sullivan

**ENT**

Dr. C. Que Hee

**Fracture Clinic**

Dr. J. Radovanovic

**Gastroenterology**

Dr. J. Wittmann

**General Medical**

Dr. M. King

**General Surgical**

Dr. M. Carmody

**Gynaecology**

Dr. M. Beckmann

**Gynae / Oncology**

Dr. L. Perrin

**Haematology**

Dr. L. Catley

**Infectious Diseases**

Dr. J. McCormack

**Maxillofacial Surgery**

Dr. B. Erzetic

**Nephrology**

Dr. J. Burke

**Neurology**

Dr. C. Staples

**Oncology**

Dr. C. Shannon

**Ophthalmology**

Dr. A. Kwan

**Orthopaedic**

Dr. S. Journeaux

**Palliative Care**

Dr. J. Hardy

**Respiratory**

Dr. D. Serisier

**Rheumatology**

Dr. J. O'Callaghan

**Urology**

Dr. R. Watson

**Vascular Surgery**

Dr. P. Bryant

**If updated referral**

Other

Dr. ....

Updated referral:  Yes  No

**Duration of referral:**

3 months (*standard referral from a specialist*)

12 months (*standard referral from a GP*)

Indefinite (*chronic conditions only*)

Date of referral: ..... / ..... / .....

**FAX COMPLETED FORM TO MATER:**

**(07) 3163 8548**

**Referring clinician to complete all fields clearly**

Date of referral: ..... Provider number: .....

Referring clinician name: .....

Practice address: .....

Phone number: ..... E-mail: .....

Fax number: ..... Referring clinician signature: .....

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