Mater Adult Hospital

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

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

.....

Relevant clinical history / Examination: .....

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Allergies: .....

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Relevant investigations:

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Medications:

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All clinical form creation and amendments must be conducted through Health Information Services.

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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

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

Duration of referral:
☐ 3 months *(standard referral from a specialist)*
☐ 12 months *(standard referral from a GP)*
☐ Indefinite *(chronic conditions only)*

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: .....