NSW GOVERNMENT Health

Facility:

REFERRAL / CONSULTATION

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REFERRING DOCTOR Provider Number Patient Status (circle) Public / Private	ATTENDING SPECIALIST (AMO)

REFERRED TO: .....(name) of .....(dept) (complete both)

Date ..... Signature ..... ***Consult team contacted?*** ☐ ***& Date*** ..... ***Time*** .....

Reason for consultation: .....

Provisional diagnosis: .....

Summary of clinical condition: .....

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Object of consultation: ☐ Advise on management ☐ Share management ☐ Take over care of patient

CONSULTANT'S REPORT: .....

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(Use Clinical Notes if more space is needed)

As requested I shall: ☐ Advise on management ☐ Share management ☐ Take over care of patient

Date ..... Signature .....

Billable Patients Only (To be completed by Medical Officer undertaking consultation)

Date seen ..... Item ..... AMO initial ..... **Date seen** ..... Item ..... AMO initial ..... **Date seen** ..... Item ..... AMO initial .....

White Copy – **MEDICAL RECORD COPY** Yellow Copy - **CONSULTANT'S COPY** Green Copy - **BILLING SERVICES COPY**

SMR050010

BINDING MARGIN - NO WRITING

REFERRAL / CONSULTATION

SMR050.010

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