REFERRAL TO KAREENA PRIVATE HOSPITAL

Emergency Department **Telephone:- 9717 0250** **Fax:- 9717 0138**

Reason for Referral: ☐ Assessment ☐ Further Investigation

☐ Other

Patients Details:-

Full Name:- Preferred V.M.O.:-

D.O.B:- VMO Contacted:-

Full Address:-

Doctors Details:-

Insurance:

☐ Privately Insured ☐ DVA ☐ Uninsured

Dear Doctor,

Thank you for seeing the patient listed above with a Provisional Diagnosis of:- ALLERGIES:-

History, clinical findings and investigations of present illness:

PAST MEDICAL HISTORY:

CURRENT MEDICATIONS:

Smoking: (number per day): Alcohol (standard drinks per day):

Other Substances:

Communication Problems	**ADL Assistance**	**Accommodation**	**Living Arrangements**	**Community Services Involved**

Referring Doctor:

Signature: _____ **Date:** _____