Information for General Practitioners
Fax this form directly to the hospital site.
Patients requiring medical assessment should be referred via the Central Referral Service.

Referrals for Cardiovascular and Pulmonary Rehabilitation require a confirmed diagnosis.

PATIENT DETAILS – complete or attach

Previous name/s:

Phone: Mobile: Email:

Country of Birth: Indigenous status: Aboriginal / Torres Strait Islander

Interpreter required: Yes No Language and dialect:

NOK: Relationship: Phone:

Medicare Number: Ref. no: Exp:

DVA health card: Gold White Orange

GENERAL PRACTITIONER DETAILS

GP name: Ph: Fax:

Practice Name: Email:

RELEVANT MEDICAL SPECIALIST DETAILS (e.g. Cardiologist, Respiratory Physician)

Name: Hospital/Site

SERVICE REQUEST

☐ Community Rehabilitation (Interdisciplinary rehabilitation team)
☐ Falls Specialist
☐ Medical Review (internal referrers only)
☐ Cardiovascular Rehabilitation (CVR)
☐ Pulmonary Rehabilitation (PR)
☐ ACAT (Aged Care Assessment Team)
☐ Permanent care ☐ Respite
☐ Services at home
☐ CAEP (Community Aids & Equipment Program)
☐ Continence clinic

☐ Clinical Psychology
☐ Dietetics
☐ Nursing
☐ Occupational Therapy
☐ Physiotherapy
☐ Podiatry
☐ Social Work
☐ Speech Pathology
REASONS FOR REFERRAL/CLIENT CENTRED GOALS

MEDICAL HISTORY / STATUS (PMHx, allergies, precautions, red flags)
☐ Investigation results/medications/medical summary attached
☐ Discharge summary attached

For CVR & PR referrer must provide: details of Oxygen Therapy; Lung Function (FEV₁ & FVC required for PR).
- if available: 6 minute walk test, echo report, stress test, angiogram, ventricular function;

Current exercise / activity tolerance:

SOCIAL SITUATION (eg living arrangements, carers, services in situ, red flags)
☐ Documents attached
☐ Safety risk for staff visits – advise below

REFERRER DETAILS (if listed GP sign and date only)
Name: ____________________________
Title/Position: ____________________________
Phone: ____________________________
Fax: ____________________________
Email: ____________________________
Address/Location: ____________________________
Feedback requested ☐ Yes ☐ No
Signature: ____________________________
Date: ____________________________

TRIAGE SUMMARY
TRIAGE OFFICER USE ONLY – REFERRERS DO NOT COMPLETE

Service(s): ____________________________
Clinician(s)/Clinic(s): ____________________________

Priorities:
☐ Urgent
☐ Semi-urgent
☐ Routine

Comments: ____________________________

Triage Officer: ____________________________
Signature: ____________________________
Date: ____________________________