**WCH Outpatient Referral: PAEDIATRICS**

**Fax completed form to: 08 8161 6246**

Phone WCH 08 8161 7399 to follow up or cancel referral

**Full list of WCH Paediatric clinics, referral guidelines and clinic information**:

[https://www.wch.sa.gov.au/professionals/referrals-to-outpatient-clinics](https://aus01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.wch.sa.gov.au%2Fprofessionals%2Freferrals-to-outpatient-clinics&data=05%7C01%7CHelen.Parry%40sa.gov.au%7C8d3559969a9642ad45fe08daabd71526%7Cbda528f7fca9432fbc98bd7e90d40906%7C1%7C0%7C638011237569322766%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=WPc4MhN4KSiZ1DdlKozUUV2nNBltdHqXZEJAWFAbyb0%3D&reserved=0)

Date:

**WCH Clinic required:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details** | Name:  Address:  Phone: | | Age:  Date of Birth:  Sex:  Gender Identity: |
| Medicare details | Medicare No.: | | Medicare Expiry Date: |
| Legal Guardian/ Parent/ Carer | Name:  Email:  Address/ Phone (If different to above): | | Relationship to child:  Consents to referral: q Yes q No |
| Parent/ Carer 2 | Name:  Phone: | | Relationship to child: |
| Is this patient of **Aboriginal and/ or Torres Strait Islander origin?** | | | q Yes q No |
| Is this patient under the **Guardianship of the Minister?** | | | q Yes q No |
| DCP case worker (if known): | | DCP contact details/ office: | |
| **Interpreter** | Interpreter required: q Yes q No | | Language: |
| Family Court order? q Yes q No | | NDIS? q Yes q No | |
| **Catchment area** | Patient lives in which Local Health Network (LHN): | |  |
| ***Country LHNs:*** *eligible for all hospitals* | ***NALHN:*** *refer to LMH for General Paediatrics, ENT (5 years and over) and Orthopaedics*  ***SAHLN:*** *FMC for General Paediatrics, Allergy, Ophthalmology, ENT (5 years and over) and range of subspecialty clinics (list on website)* | | |

|  |  |  |
| --- | --- | --- |
| **Referring Doctor:**  Provider Number: | Name:  Qualifications: | Practice Name and Address: |
| Phone: | Fax: | Practice Email: |
| Referring Doctor's signature: |  | Date: |

**Reason for Referral:**

Dear Doctor,

Thank you for seeing

|  |  |
| --- | --- |
| |  | | --- | | *ENT referrals for suspected/ confirmed hearing loss: please attach recent Audiogram Ophthalmology: include eye and vision assessment of each eye (age appropriate)* | |

**Medical History:**

**Allergies:**

**Current Medications:**

**Social History:**

**Family History:**

**Observations:**

* Height =
* Weight =
* Percentile:

**Immunisation History:**

q Up to date

q Not up to date

**Investigations:**

|  |  |  |  |
| --- | --- | --- | --- |
| **WCH Office Use Only** | | | |
| **MRN #:** | | **Visit ID#:** | |
| **Clinic:** | | **Pre-triaged:** | |
| **Appt Date:** |  | **Appt Time:** |  |
|  | | | |
| **WCH Clinician Use Only** | | | |
| **Triaged by:** |  | **Date Triaged:** |  |
| **Appointment type:** | q NEW | q REVIEW |  |
|  | q Face to Face | q Video | q Telephone |
| **Confirm Clinic:** |  | **Confirm Consultant:** |  |
| **Triage Category** | | | |
| **q Rapid Access** | **q P1** | **q P2** | **q P3** |