

Rheumatology Service Referral Form

Belvidere Health Centre



| | | | |
|---------------|--|--------------------|--|
| Referral Date | | Feedback Requested | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---------------|--|--------------------|--|

Patient details

| | | | |
|----------------------|--|------------------|--|
| Name | | Title | <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss |
| DOB | | Sex | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Indigenous Status | <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither | | |
| Address | | | |
| Phone (home) | | Phone (work) | |
| Email | | Phone (Mobile) | |
| Interpreter Required | <input type="checkbox"/> Yes <input type="checkbox"/> No | Language | |
| DVA Number | | Pension Card No. | |
| Insurance Provider | | Medicare No. | |

Emergency Contact

| | | | |
|-------|--|--------------|--|
| Name | | | |
| Phone | | Relationship | |

Referring GP Details

| | | | |
|----------|--|--------------|--|
| Name | | Provider No. | |
| Practice | | | |
| Address | | | |
| Phone | | Fax | |
| Email | | Mobile | |

Reason for Referral

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Clinical information

| | |
|--|--|
| Health Summary <i>(attach health summary, allergies and warnings, medications)</i> | |
| Investigation / test results | |

Consent

| | |
|--|------|
| The patient has provided consent to this referral and sharing of relevant information. | |
| Signature | Date |

Please send the referral form to Dr Priya Chowalloor (Consultant Rheumatologist) at Belvidere Health Centre by fax (08) 6253 2199 OR email admin@belhealth.com.au. For any enquiries regarding this service, please contact (08) 6253 2100.

Belvidere Health Centre



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