West Moreton Health Central Referrals Hub

SPECIALIST OUTPATIENT REFERRAL FORM Ipswich Hospital Outpatient Department

Urgent Fax line 3413 7277 Routine Fax 3810 1438

WMH encourages the utilisation of GPSR software to submit referrals
Please contact WM_digital_health@Health.qld.gov.au

The below contact numbers are for Referring Practitioners only, If your patient is:

- An **Emergency transfer** to the emergency department and additional information has been requested, fax directly to 38101764. For more information on alternatives to our ED department see: *https://westmoreton.communityhealthpathways.org/1421407.htm*
- For the **Medical Rapid Access Clinic (MRAC)** - Call 3413 5868
- For the **Preventative Integrated Care Service (PICS)** - Call the CNC triage line on 0409 594 866
- For **Hospital in the Home (HITH)** - Call the intake line on 0418 177 831

General information about referrals

For further information regarding Clinical Prioritisation Criteria (CPC) and Referral Guidelines for medical conditions suitable for referral to WMH Specialist Outpatient Clinics please visit: https://westmoreton.communityhealthpathways.org/ ***or*** https://www.westmoreton.health.qld.gov.au/for-health-professionals/refer-your-patient *CPC and Guidelines also include information about specific conditions that should be considered 'emergency referrals' and be sent directly to the Emergency Department and those that are considered 'out-of-scope' for public outpatient services.*

Referral Information

Urgency of referral:

Referral Date:

Length of referral?:

Referral Type:

Reason for Triage Upgrade request:

Is this a named referral?: Yes

Specialty Referred to

Antenatal Only - Is this GP Shared Care?

Reason for Referral (clinical condition e.g. L Knee Pain):

Have all essential referral criteria (CPC) requirements been addressed?

Reason for Clinical override?

Presence of Clinical Modifier(s)? (copy and paste all that apply)

Impact on employment; education; home; activities of daily living (low/medium/high); ability to care for others; personal frailty or safety

Please type all further information regarding referral and clinical override here:

Please include ALL standard, essential referral information.

Other referral information

Could Case conference be considered for Complex and Palliative Chronic disease patients?

Patient Details ***Next of kin must be completed for children under the age of 18***

Full name:

Preferred Name: Date of Birth: 01/13/2026 Age in Years: 0.5

Birth Sex Gender: Pronouns:

Street Address:

Suburb: State: Postcode:

Postal Address:

Phone (Home): Phone (Work): Phone (Mobile):

Medicare Number: Medicare Line number: Medicare expiry:

DVA Number (if applicable): Card Type:

Pension number:

Private Health Insurance fund: Fund number:

Aboriginal and Torres Strait Islander status:

Ethnicity: Is the patient of refugee background?

If yes, please provide relevant details:

Interpreter Required: Preferred Language:

Next of Kin name: Next of Kin Phone:

Next of Kin Address: Next of Kin Relationship:

If the patient is a paediatric patient, are they under the care of the Department

of Child Safety? Caseworker Details (if applicable):

Does patient consent to SMS Contact from West Moreton Health?

Does your patient consent to Email contact from West Moreton Health?

Email Address:

Current and Past Clinical History

History of Current Conditions:

Current Medication List:

Allergies/Adverse Events:

Smoking Status:

Alcohol Consumption:

Relevant Social History:

Relevant Family History:

Observations

Height: Weight: BMI:

Referring Doctor Details

Doctor: Provider No:

Practice Name: Practice HPI-O:

Doctor Address:

Phone:

Fax:

Email:

Are any other practitioner involved in care of the patient?

Patient's Usual GP (if different from referrer):

Electronic Verification and Signature

Date:

Recent/relevant Investigations & notes

Copy and paste from patient's clinical records or attach separately with referral

Print Save form Reset form