CAMDEN AND CAMPBELLTOWN HOSPITALS
ADULT OUTPATIENTS CLINIC REFERRAL FORM

Health
South Western Sydney
Local Health District

Date _____

Dear _____

Re: Patient / client details

Name:

Date of Birth: / /

Preferred name/s:

Sex: Male Female

Address:

Phone: **Work:**

Mobile:

Reason for patient referral

Other notes (eg current services)

Clinical information

Warnings:

Allergies:

Current Medication:

Drug name	Ltd. elapse	Strength	Dose / frequency / special

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Social History:

Past Medical History:

Investigation / Test Results:

Referring doctor: _____

Provider Number: _____

If an appointment is available earlier with another clinician of the same speciality or more appropriate clinician, would you like this patient to be booked in for an earlier appointment? **Yes** **No**