Government of South Australia
SA Health

STATEWIDE STANDARD OUTPATIENT REFERRAL FORM

REQUEST FOR OUTPATIENT APPOINTMENT (MR15)

Hospital: .....

Affix patient identification label in this box

UR Number: .....

Surname: .....

Given name: .....

Second given name: .....

D.O.B: __ __ / __ __ / __ __ __ __ Sex: .....

Specialist name or "doctor on duty"			
Hospital		Clinic	
Alternative hospital(s) where patient willing to be seen			
Urgency of appointment			

Patient Details			
Surname		Given names	
Date of birth		Gender	
Address			
State		Postcode	
Postal address (if different than above)			
State		Postcode	
Preferred phone		Alternative phone	
Medicare number		Expiry date	
Is the patient of Aboriginal or Torres Strait Islander origin?	☐ No, neither ☐ Yes, Aboriginal	☐ Yes, Torres Strait Islander ☐ Yes, both	
Is an interpreter required?	☐ Yes ☐ No	Language	
Patient carer details (if relevant)			
Other considerations and patient require-ments (eg. Visually impaired, literacy level)			
DVA/Compensable details	☐ Workers compensation ☐ Motor vehicle accident ☐ Veterans affairs	Compensation/ DVA No.	
For veterans affairs patients only			
Has the patient served in the ADF (Australian Defence Forces)?	☐ Reserves ☐ Permanent ☐ Both	Has the patient served over-seas?	
For paediatric patients only			
Is the patient under the Guardianship of the Minister?		☐ Yes ☐ No	
Parent/Guardian name		Relationship to child	

Binding margin - no writing

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Referral Information	
Name of specialist or Dr on duty	
Referral duration	☐ 3 months ☐ 6 months ☐ 12 months ☐ Indefinite
Patient's presenting symptoms	
Reason for referral *(Tick more than 1 option where appropriate)*	☐ Assessment only ☐ Diagnostic procedure ☐ Assessment and management ☐ Second consultant opinion ☐ Hospital to share management with GP
Current medical conditions	
Current medications	
Recent investigations and results	
Relevant past medical history	
Allergies	
Relevant social factors	
Other relevant health professionals involved in the patient's care (including contact details)	

Referrer Information			
Referrer's name		Provider number	
Practice name		Practice phone	
Practice address			
Referrer's signature		Date	

General Practitioner details (if not referrer)			
Doctor's name		Surgery name	
Surgery address		Surgery phone	

Binding margin - no writing