Ballarat Health Services
Putting your health first®

Allied Health Outpatient Referral Form

U.R. Number ____________________
Surname ____________________
Given Names ____________________
D.O.B. / / Sex ____________

AFFIX PATIENT LABEL HERE

Once completed please fax to Allied Health Central Intake Fax 03 5320 3893

If the referral is urgent, please contact Central Intake on 5320 6690

Date of referral: _____ /______ /________

Referrer's details

Referrer's Name: ____________________ Signature: ____________________

Designation: ____________________ Referring Unit: ____________________

Unit contact person: ____________________ Phone: ____________________

Reason for referral (For what problem is the patient being referred?)

____

____

Proposed discharge date (if applicable): _____ /_____ /_________

Has patient/carer consented to this referral? ☐ Yes ☐ No

Has patient carer been informed of this referral?: ☐ Yes ☐ No Details: ____________

Relevant Medical or Surgical History

____

____

____

Planned Medical Follow up: ____________________

____

Current status

____

____

____

Are there any risks to the clinician? (e.g. physical, behavioural, environmental) ☐ Yes ☐ No

Comment: ____________________

Referral request/Discipline(s) required

Discipline	**Program**
☐ Dietetics	☐ ABI
☐ Exercise physiology	☐ Continence
☐ Occupational therapy	☐ Gait and Balance
☐ Physiotherapy	☐ Healthy Weight Management
☐ Podiatry	☐ High Risk Foot Clinic
☐ P & O	☐ Persistent Pain Management
☐ Psychology	☐ Pulmonary Rehabilitation
☐ Social work	☐ Other: ____________
☐ Speech Pathology	

BHS PS
Jun 15