

If this referral is **URGENT**  
 please ph: 07 3163 7362  
 to discuss with our staff

**URGENT**

## PAEDIATRIC REFERRAL

### Referral to:

<b>This referral is to:</b>	<b>Dr Julie Beak</b>	<b>&amp;/or</b>	<b>Dr Haseena Mohamed</b>
<b>Phone:</b>	<b>3163 7362</b>	<b>Post:</b>	<b>Mater Specialist Suites</b>
<b>Fax:</b>	<b>3163 7364</b>		<b>Suite 11-12</b>
<b>Email:</b>	<a href="mailto:Reception@mbog.com.au">Reception@mbog.com.au</a>		<b>Weippin Street</b>
			<b>Cleveland Qld 4163</b>

### Patient Details:

<b>Name:</b>	<b>DOB:</b>
<b>Address:</b>	<b>Suburb:</b>
<b>Phone:</b> H) M) W)	
<b>Medicare Number:</b> <input type="text"/>	<b>Medicare ref:</b> <input type="checkbox"/> <b>Expiry date:</b>
	<b>Parent/Guardian Medicare ref:</b> <input type="checkbox"/>
<b>Private Health Insurance:</b> Yes / No	<b>Fund:</b>
	<b>Member No:</b> <input type="text"/>
<b>Next of kin/ Carer's name:</b>	<b>Relationship:</b>
<b>Name:</b>	<b>DOB:</b>
<b>Address:</b>	<b>Suburb:</b>
<b>Phone:</b> H) M) W)	

### Clinical Information:

<b>Reason for Referral:</b>	<b>Duration of referral</b> <input type="checkbox"/> 3 months <input type="checkbox"/> 12 months
<b>Presenting Symptoms (evolution and duration):</b>	
<b>Investigations (please attach to referral or company used):</b>	
<b>Relevant Medical/ Surgical history:</b>	
<b>Relevant Family/ Social history:</b>	
<b>Current Medications (attach list if necessary):</b>	
<b>Immunisation history:</b>	
<b>Alerts/ Allergies:</b>	

### Referring Medical Officer Details:

<b>Name:</b>	<b>Date:</b>
<b>Signature:</b>	<b>Provider no:</b>
<b>Practice Name:</b>	<b>Suburb:</b>
<b>Address:</b>	<b>Email:</b>
<b>Phone:</b>	<b>Fax:</b>