ST JOHN OF GOD
Midland Public Hospital

REFERRAL FORM – General

Only completed forms will be accepted via:

- ☐ SJG Midland Referrals, PO Box 268, Midland WA 6936
- ☐ MI.Referrals@sjog.org.au
- ☐ Fax: (08) 9462 4085

Phone: (08) 9462 4293

Operated by St John of God Health Care in partnership with the Government of Western Australia

Referral to

Specialty _____ Specialist (if known) _____ Date _____

Patient details

URN hospital no. _____ Title _____ Gender _____

Surname _____ First name _____ D.O.B _____

Previous name/s _____ Mobile _____

Address _____ Phone _____

Suburb & postcode _____ Email _____

Marital status _____ Religion _____ Medicare no. _____

Country of birth _____ Interpreter? _____ Reference no. _____

Indigenous status _____ Language _____ Expiry date _____

Next of kin/carer

Relationship _____

Name _____

Address _____

_____

Phone _____

Referrer details

Usual GP? ☐ Yes ☐ No

Referrer name _____ Provider no. _____

Practice name _____

Address _____

Suburb _____ Postcode _____

Phone _____ Fax _____

Referral details

Urgency ☐ P1 (30 days) ☐ P2 (90 days) ☐ P3 (365 days)

Reason for referral _____

_____

_____

_____

*Please attach any relevant diagnostic reports

Significant medical history _____

_____

_____

Current medications & treatment used _____

_____

_____

_____

Allergies _____ Height _____ Weight _____ BMI _____

Referring Doctor's signature _____ Date _____

1 Clayton Street, Midland WA 6056
PO Box 1254, Midland WA 6936
T. (08) 9462 4000 **F.** (08) 9462 4050
E. info.midland@sjog.org.au

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www.sjog.org.au/midland

St John of God Health Care Inc.
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