WE CAN ONLY ACCEPT TYPED REFERRALS – HANDWRITTEN REFERRALS WILL NOT BE PROCESSED

Neurosciences Consulting Rooms Referral Form – Epilepsy and 1st Seizure

ST VINCENT'S HOSPITAL MELBOURNE

FAX or EMAIL this form to: (03) 9231 3038 or neuroscience@svhm.org.au
Neurosciences Consulting Rooms – Level 5, Building D, 35 Victoria Parade, Fitzroy - Phone: 9231 3045

YOUR REFERRAL CANNOT BE ACCEPTED & PROCESSED WITHOUT THE FOLLOWING ESSENTIAL DETAILS

REFERRAL DATE:	

CLINICAL URGENCY:	Routine

Referring Doctor Details	
Name:	
Provider Number:	
Practice Name:	
Practice Address:	
Phone:	
Fax:	

Patient Details			
St. Vincent's UR (if known)		**Date of Birth:**	
Surname:		**Given Name/s:**	
Address:			
Home Phone:		**Mobile:**	
Medicare No:		**Aboriginal or Torres Strait Islander**	No

Interpreter Required:	☐ **No** ☐ **Yes**	Language:	

Has the patient agreed to this referral and consents to the sharing of their personal and health information with SVHM? (tick to confirm) ☐

Sub-speciality		
Sub-speciality	**Provider**	
Epilepsy & 1st Seizure	Prof Mark Cook	☐

Clinical Information:	
Reason for Referral: Include: Onset, characteristics and frequency of seizures	
Current Medications Attached?	No
Past History Attached?	No
Recent Investigation Results Attached?	No
Adverse Reactions & Medical Warnings Attached?	No
Is the Patient Pregnant	No