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

# Neurosciences Consulting Rooms Referral Form – Headache

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 2898

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

| | |
|---|---|
| **REFERRAL DATE:** | |

| | |
|---|---|
| **CLINICAL URGENCY:** | Urgent |

| **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 healthinformation with SVHM? (tick to confirm) ☐

| **Sub-speciality** | | |
|---|---|---|
| **Sub-speciality** | **Provider** | |
| Headache | Dr Christina Sun-Edelstein | ☐ |

| **Clinical Information:** | |
|---|---|
| **Reason for Referral:** | |
| **Current Medications Attached?** | No |
| **Past History Attached?** | No |
| **Recent Investigation Results Attached?** | No |
| **Adverse Reactions & Medical Warnings Attached?** | No |