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 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**	
Headache	Dr Christina Sun-Edelstein	☐

Clinical Information:	
Reason for Referral: (refer below for essential clinical information)	

This referral must contain the following essential clinical information:

- Onset, characteristics and frequency of headache
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Any medicines previously tried, duration of trial and effect
- Erythrocyte sedimentation rate and C-reactive protein for patient > 50 years, or if giant cell arteritis or vasculitis suspected
- Details of any previous neurology assessments or opinions

Current Medications Attached?	No
Past History Attached?	No
Recent Investigation Results Attached?	No
Adverse Reactions & Medical Warnings Attached?	No