Health
Northern NSW
Local Health District

Facility:

REFERRAL COVERSHEET

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Note to referrer: do not fill section above – LHD/office use only

Please use this coversheet when faxing a new referral, updating an existing (previously sent) referral or providing requested/ missing information (e.g. results) to an existing referral. Please fill this form in on a computer or use clear, capitalised text (BLOCK CAPITALS). X instead of tick in check boxes please.
ALL FIELDS are required.

Please ensure any investigations/results are included to avoid delays to triage. Check HealthPathways for required information for the service if applicable.

Type of Referral: ☐ New ☐ Update to existing ☐ Providing requested/missing information to existing	Referred-to Service Name: Location of Service *(eg Lismore Base)*:
To/recipient *(where applicable include named specialist if known)*	Recipient Fax No: Number of pages *(excluding coversheet)*:
Patient First Name:	Patient Last Name:
Patient DOB *(dd/mm/yyyy)*:	Patient Sex: ☐ MALE ☐ FEMALE ☐ OTHER
Referral ID *(if provided by LHD)*	Referral Urgency: ☐ Non-urgent ☐ Urgent
Patient Medicare Number:	Referral Fax Number:
Referrer First Name:	Referrer Last Name:
Referrer Practice/Organisation Name:	Referrer Medicare Prov No *(PRN)*: Referrer Phone number:
Patients preferred contact method – X all that apply and supply detail: ☐ SMS ☐ Phone/voicemail ☐ Email ☐ Post *(please include address in referral)* Note: sending of a referral indicates you have patient consent. We may contact the patient to make an appointment and this can include leaving a voicemail on mobile/phone or sending an administrative text message	Patient mobile number: Patient home/landline: Patient email address:

PRIVACY NOTICE: The information contained within this fax message is intended for the named addressee only. If you are not the intended recipient you must not copy, distribute, take any action reliant on, or disclose any details of the information in this fax to any other person or organisation. If you have received this fax in error please notify the referrer organisation immediately.

NNSWLHD prefers eReferrals where available as they are safer and faster. Please check HealthLink Forms in Best Practice, Medical Director or Genie for enabled services, or check HealthPathways for the relevant service.

NNSW005003 080222

NNSW005003

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

REFERRAL COVERSHEET
NNSW005.003