RHC100.20
Referral/Consent

Masada Private Hospital
Part of Ramsay Health Care

Early Parenting Centre Referral Form

Fax: (03) 9038 1405

Unit Record Number: | | | | | | | | |

Admission Number: | | | | | | | | |

Family Name: _____

Given Names: _____

Date of Birth: | | | | | | | | | Age: | | Sex: | |

OR USE LABEL

Dear Doctor

To refer your patient to the Masada Early Parenting Centre, please complete this form for submission by the fax number above. These details are required to streamline admission and health fund approval.

Parent's Name: _____ D.O.B: _____ /_____ /_____

Baby's Name: _____ D.O.B: _____ /_____ /_____

Address: _____

Telephone No: _____ Mobile No: _____

Private Health fund name: _____ Private Health fund Number: _____

Provisional Diagnosis: **Parent**: _____

Provisional Diagnosis: **Baby**: _____

Duration of problem: _____

Relevant History (*ie. illness/operations in past)*: _____

_____

_____

Current Medications: _____

Previous hospitalisation for this problem? ☐ Yes ☐ No

When: _____ Where: _____

Any psychiatric problems or treatment? Please provide details: _____

_____

_____

Referring Doctor's Name: _____ _____
(PRINT) (SIGN)

Provider Number: _____

Medical Practice Name: _____

Address: _____

Post Code: _____

Telephone Number: _____

Fax Number: _____

Signature: _____

Date: _____ /_____ /_____

BINDING MARGIN - DO NOT WRITE

EARLY PARENTING CENTRE REFERRAL FORM

MR 001E