

MEDICAL REFERRAL LETTER

Referring Doctor: _____
Practice/Clinic Name: _____
Address: _____
Phone: _____ Fax: _____

Patient Details:

Full Name: _____
Date of Birth: _____
Address: _____
Phone: _____

Referred To:

Doctor/Specialist Name: _____
Practice/Clinic: _____
Address: _____
Phone: _____

Referral Details:

Please see the patient for the assessment and management of the following condition(s) or concern(s):

- Detailed history and clinical examination
- Relevant investigations and reports attached
- Specific questions or concerns for the specialist
- Patient's current medications and allergies
- Any urgent or priority considerations

Clinical Information Provided:

Attached are copies of relevant clinical information to assist ongoing care, including but not limited to:

- Past medical history
- Previous investigation results (e.g. imaging, pathology)
- Summary of current clinical status and treatment
- Any other pertinent information

Patient Consent and Privacy:

The patient has consented to this referral and understands that their personal health information will be shared with the referred health professional for the purpose of diagnosis, treatment, and ongoing care, in accordance with the Privacy Act 1988 (Cth) and Australian Privacy Principles.

Important Legal Information:

This referral letter constitutes a formal request for medical services and is governed by the laws of Australia. It is prepared in accordance with relevant professional standards and legal requirements. The referring practitioner certifies

that the information provided is true and accurate to the best of their knowledge. The patient is advised to disclose any change in health status to the referred practitioner promptly.

Referring Doctor's Signature

Patient's Signature

Signature: _____

Signature: _____

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