Central Coast
Local Health District

Facility: COM GOS LJ WW WYG

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. DD / MM / YYYY	M.O.
ADDRESS	
	PH
M / C	FIN
LOCATION / WARD	ADM DD / MM / YYYY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REFERRAL - WYONG PAEDIATRIC UNIT (WPU)

COR5217

This referral is for a PAEDIATRIC REFERRAL for patients to attend the WYONG PAEDIATRIC UNIT OUTPATIENT CLINIC.

PATIENTS WILL RECEIVE AN APPOINTMENT LETTER FROM THE HOSPITAL WITH THE DATE AND TIME OF THEIR APPOINTMENT
Please contact the Wyong Paediatric Unit via ph: 4394 7586 or email: CCLHD-wyongpaediatric@health.nsw.gov.au for any enquiries regarding your appointment.

Enter today's date: __ / __ / ____

Dear ☐ Dr V Malhotra ☐ Dr E Pascoe ☐ Dr M Rattan ☐ Dr D Susa ☐ Dr S Thit San
☐ Wyong Paediatric Outpatient Clinic

Patient name ..... Patient D.O.B: __ / __ / ____

Patient/Carer name .....

Parent/Carer phone ..... Parent/Carer email .....

Presenting complaint is for: ☐ Medical concerns ☐ Behavioural concerns

Presenting Complaint:

GP to attach copy of growth chart if referred for:

☐ FTT ☐ Weight Issues (elevated BMI) ☐ Growth Issues (eg: short stature) ☐ Head Circumference concerns

Developmental milestones: ☐ Meeting all

Areas of concern: ☐ Speech ☐ Socialisation ☐ Motor Other: .....

Current supports: ☐ Nil ☐ Child & Family Health ☐ Allied Health

Specialty involvement:

☐ Gastro ☐ Ortho ☐ Surgical ☐ Respiratory ☐ Allergy ☐ Private Paediatrician

Other: .....

Additional information (required)

Current height (cm): ..... Centile: ..... Current weight (kg): ..... Centile: .....

BMI (> 2 yrs) ..... Centile: .....

Head Circumference <3 yrs (cm): ..... Centile: .....

Additional information (if relevant)
Previous medical history:

Relevant Pathology: (Please attach relevant reports)

Pathology pending: .....

Holes punched as per AS2828.1:2019
BINDING MARGIN – NO WRITING

CATALOGUE NUMBER CC12556-E MAY23/V2

REFERRAL WYONG PAEDIATRIC UNIT (WPU)

Central Coast
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REFERRAL - WYONG PAEDIATRIC UNIT (WPU)

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Referred to additional services:

☐ Gosford Staff Specialist Centre ☐ Private Paediatrician

Sub-Specialist: ☐ Gastro ☐ Ortho ☐ Surgical ☐ Oncology ☐ Respiratory ☐ Allergy

Other: .....

Yours sincerely, (signature required) Dr. Provider Number:	**Referral Valid for:** ☐ 3 months Specialist Ref ☐ 12 months Gen Ref ☐ Indefinite Chronic Existing Condition
First name:	
Last name:	
Contact number:	Contact email:
Practice name:	
Practice address:	

For Paediatrician Use Only

Triaging Doctor: ☐ Dr V Malhotra ☐ Dr E Pascoe ☐ Dr Rattan ☐ Dr D Susa ☐ Dr S Thit San

Other: .....

Triage Category: ☐ 1 month ☐ 2 Months ☐ 3 months ☐ Routine ☐ Urgent Behaviour ☐ Routine Behaviour

Can be seen by: ☐ RMO ☐ Reg ☐ Fellow ☐ Consultant ☐ Allergy ☐ CFHN

Suggestions: ☐ Speech ☐ Psychology ☐ School Reports Other: .....

Administration Only			Staff Initial
Initial Referral received SMS	Date: __ / __ / ____		
1st message left/ SMS	Date: __ / __ / ____		
2nd message left / SMS	Date: __ / __ / ____		
Unable to contact letter sent	Date: __ / __ / ____	☐ Patient	☐ GP

Appointment Details	Dr Name
Date: __ / __ / ____ Time: __ : __	
Date: __ / __ / ____ Time: __ : __	
Rescheduled Appointment Details	**Dr Name**
Date: __ / __ / ____ Time: __ : __	
Date: __ / __ / ____ Time: __ : __	
Date: __ / __ / ____ Time: __ : __	

Patient advised of process: ☐ Yes ☐ No

Patient requires interpreter: ☐ Yes ☐ No Language ..... Auslan: ☐ Yes ☐ No Booking ref: .....

Patient declined appointment due to:

☐ Relocation ☐ Alternative Provider / Private ☐ Appointment no longer required

Holes punched as per AS2828.1:2019

BINDING MARGIN – NO WRITING