



Facility: COM GOS LJ WW WYG

REFERRAL - WYONG PAEDIATRIC UNIT (WPU)

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

**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:

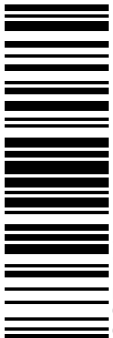
Head Circumference <3 yrs (cm): Centile:

Additional information (if relevant)

Previous medical history:

Relevant Pathology: (Please attach relevant reports)

Pathology pending:



COR5217



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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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)			Referral Valid for:			
Dr.			3 months Specialist Ref		12 months Gen Ref	
Provider Number:			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		

Notes punched as per AS2828.1:2019
BINDING MARGIN - NO WRITING