Fast Track Emergency

Specialist Referral Form

After-hours FACEM support

For patients:

Scan the QR code to start your consult

Or vist us at fasttrackemergency.com.au

SCAN ME

Patient details

First name:

Surname:

Date of birth:

Phone no:

Reason for referral

Please tick all that apply or supply clinical details

- ☐ Gastroenterology (post op concerns)
- ☐ Orthopaedics (post op concerns)
- ☐ ENT (post op concerns)
- ☐ Ophthalmology (eye concerns)
- ☐ Pain management
- ☐ Urology (post op concerns)
- ☐ Plastics / reconstructive
- ☐ Dental / Oral surgery
- ☐ Gynaecology
- ☐ Other surgical speciality
- ☐ Wound concerns
- ☐ Bleeding concerns
- ☐ Infections concerns
- ☐ Medication / pain management
- ☐ Other (please specify)

Clinical details:

Referrer details

First name:

Surname:

Provider number:

Phone no:

Practice / Facility:

Provider stamp:

Signature:

Date: