Rockdale Women's Health Clinic Referral Form

Clinic Location: **Rockdale Community Health Centre**
16-18 King St Rockdale

To provide our clients with the very best and most comprehensive care we need to have accurate and up to date information to assist us in decisions regarding their clinical care.

Please complete the following information to enable us to make an appointment for your client.

Client Details

Name _____ DOB_____ M / F

Address _____

Postcode _____

Phone _____ (Mob) _____ Email _____

Interpreter: Yes / No Language Required _____

Medicare No _____ Pension/Health Care Card No _____

Aboriginal/Torres Strait Islander: Yes / No

Referrer (GP) Details

Referrer Name _____ Date _____/_____/_____

Address_____

Postcode_____ Phone Number _____ Fax Number _____

Referrer's Provider No _____

☐ Client has consented to this referral

☐ Consents for results/correspondence to be sent to referrer

Presentation Details

Please indicate clinical service required / or details of client's presenting issue(s)

_____

_____

☒ Cervical screening

☐ Breast check/education ☐ Pelvic floor assessment

☐ Opportunistic STI screening ☐ High vaginal swab

PLEASE FAX REFERRAL TO

Family Planning NSW, Fairfield - FAX (02) 9723-0922

For More Information:

Phone (02) 9754-1322 or **Email** rockdaleappts@fpnsw.org.au