Print Reset Form

Queensland Government

Royal Brisbane and Women's Hospital

QUEENSLAND RENAL GENETICS CLINIC REFERRAL FORM

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Address:

Contact Number:

Medicare Number:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Please tick: ☐ Dr Chirag Patel

Referral summary letters are also welcome.

Complete all sections, sign and fax to:
1300 364 952
(Metro North Central Patient Intake Unit)

For urgent referrals or clinical queries please contact the on-call team: 07 3646 1686

☐ Patient / family aware of referral	Speciality:
☐ Translator Required Language:	Consultant / GP Name: Consultant / GP Provider Number:
☐ Urgent *(indication)*: ☐ Non-Urgent	Contact Number: Address:

Clinical information:

Diagnosis and relevant family history:	*Please attach all relevant investigations:*
	- *Renal function* - *Urinary studies* - *Renal imaging (USS/CT/MRI)* - *Renal biopsy*

Reason for referral:

Doctor's Name:	Designation:	Signature:	Date:

MR 61403
V4.10 - 11/2023
Locally Printed
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