



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

Consultant / GP Name:

Language:

Consultant / GP Provider Number:

Urgent (*indication*):

Contact Number:

Address:

Non-Urgent

### 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:

DO NOT WRITE IN THIS BINDING MARGIN

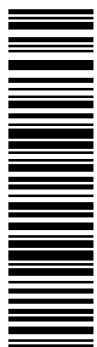
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All clinical form creation and amendments must be conducted through Health Information Services

MR 61403

V4.10 - 11/2023

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