

Peninsula Health

**REFERRAL TO  
GESTATIONAL DIABETES  
CLINIC**

UR NUMBER ..... D.O.B .....

Surname..... Given Name .....

Address .....

Suburb ..... Phone ..... Gender .....  
Please fill in if no Patient Label available

App.21/5/2024 Print Code:14523

**To: A/Prof Debra Renouf - P/N 2418297Y**

Patient's second contact / mobile number: .....

Is the patient within one of the following compensable categories?

Workcover  T.A.C.  D.V.A.  Overseas visitor (ineligible for Medicare)

**Referrer Details:**

Name of Referring Dr (print): ..... Date of Referral: ...../...../.....

Signature: ..... Phone No: .....

Provider Number (mandatory): .....

**Referrals without a valid Medicare provider number from the referring doctor cannot be processed**

**Reason for Referral:** .....

.....  
.....  
.....  
.....

Gravida: ..... Para: ..... EDD: ..... Weeks Gest: ..... BMI: .....

Result of OGTT at: 0 hours 1 hour 2 hours

Investigations already performed:  Pathology  Radiology  Other .....

**Please fax completed referral and any relevant investigation reports to Outpatients Area 1: 9125 9846**

**OUTPATIENT OFFICE USE ONLY**

Received on: ...../...../..... Triaged by: .....

Clinic required: ..... Date: ...../...../.....

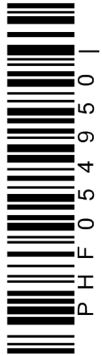
Clinic appointment booked: Date: ...../...../..... Time: .....:.....

Patient notified by:  In Person  Phone  Mail

Notified & Processed by: .....

Comments: .....

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MR/054950