# Wesley Hospitals
Ashfield and Kogarah

# Patient Referral Form

Referral Date: ____/____/____
dd / mm / yyyy

**Referral to** (please tick):

☐ **Wesley Hospital Ashfield**

91 Milton Street, Ashfield NSW 2131
Ph: (02) 9716 1400 Fax: (02) 9799 6585

☐ **Wesley Hospital Kogarah**

7 Blake Street, Kogarah NSW 2217
Ph: (02) 8197 5800 Fax: (02) 9587 2250

## Patient details:

Title (please tick): ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: _____

Gender (please tick): ☐ Male ☐ Female ☐ Nonbinary ☐ Other Date of birth: ____/____/____
dd / mm / yyyy

Surname: _____ Given name: _____

Address: _____

_____

Phone / Mobile: _____ Email: _____

Does the patient have Private Health Insurance? (please tick): ☐ Yes ☐ No

**Reason for referral**: _____

_____

_____

_____

_____

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_____

**My patient would like treatment for** (please tick):

☐ Alcohol and drug dependency ☐ Borderline personality disorder ☐ Psychosis
☐ Anxiety and depression ☐ Electroconvulsive Therapy ☐ Service-related trauma
☐ Bipolar disorder ☐ Post-traumatic stress disorder ☐ Other

**My patient is interested in** (please tick): ☐ an Inpatient program ☐ a Day program

## Referring doctor's details:

Name: _____

Provider Number: _____

Signature: _____

Please stamp General Practitioner Provider details here:

HOS49967_2303

Fax this form to the nominated hospital or email **hospitals@wesleymission.org.au**
For more information, please call **1300 924 522** or visit **hospitals.wesleymission.org.au**