Bayside Wound Group
Specialist in Wound Care & Education

Referral Form

Please complete ALL details and email to baysidewound.group@gmail.com or FAX: 03 9592 8808

Patient

Name:		Date of Birth:	
Address:		Phone:	
Emergency Contact:		Medicare No:	

Medical Professional Supporting

GP Name:		Provider #:	
Phone:		Fax:	
Specialist:		Provider #:	
Phone:		Fax:	

Referral Type: Wound Care ☐ Stoma Therapy ☐ Breast Care ☐ Diabetes ☐

Date and Type of Procedure (If Applicable):
Care Requested:

Requested First Date of Visit: ___/___/_____

Financial

Must be completed for referral to be accepted

Financial Responsibility:	Patient ☐ DVA Gold Card ☐ Hospital ☐ Third Party Approved (E.g. Health Fund)* ☐ **Third Party approval must be provided in writing and given along with referral.* Further Details (E.g. Number of Visits)_____
Referral Details:	Form Completed By: Hospital/Ward/UR Number: Phone/Fax: Signature:

Complete ALL details before sending.
Please contact Bayside Wound Group to confirm the referral has been accepted.

Shellev McIvor: 0409 545 705 Karen Wendland: 0418 123 502 FAX: 03 9592 8808