RACGP
Royal Australian College *of* General Practitioners

Request for consultation

To *(specialist/other GP)*

Name
Practice name
Address
Tel Fax

From *(referring GP)*

Name
Practice name
Address
Tel Fax

Dear

Re: Name

Date of birth / /

Address

Record no.

Suburb

Reason For Referral

Other information

Enclosed: ☐ Health summary ☐ Reports ☐ Other

Present medication

Past unhelpful medication, allergies, measures

Investigations/procedures already performed

Would you please assess and advise me on future management.

This referral is: ☐ Opinion only ☐ Valid 3 months ☐ Valid 12 months ☐ Other

Signed

Date / /

4700