

WOMEN'S HEALTH CLINIC SELF REFERRAL

To request an appointment with our Women's Health Clinic, please complete the form below, and email to



HMCWomensReferrals@hawkinsmedical.com.au

Name: _____ Date of Birth: _____

Phone: _____ Mobile: _____

Address: _____

Medicare Card: _____ Line Number: _____ Expiry Date: _____

Usual GP Clinic: _____

(Please note: We do NOT accept patients without a home clinic)

Usual GP: _____

Reason for attending (please tick):

- Contraception (including Mirena/IUD)
 - Contraception (including Implanon)
 - Emergency Contraception*
 - Pre-conception Counselling
 - Threatened Miscarriage/Miscarriage*
 - Antenatal Care – approx. weeks gestation _____
 - Postnatal Care - delivery date _____
 - Pelvic Pain
 - Heavy/Abnormal Uterine Bleeding
 - Infertility
 - Perimenopause/Menopause
 - Other/Other Information: _____
- _____
- _____
- _____

* These are time dependant conditions. If this request is received just before a weekend or Public Holiday, we may not be able to accommodate you in a timely fashion.

Before submitting this request I acknowledge that:

- this clinic is a private clinic and charges private fees
- fees for late cancellation and non-attendance of 75% of the full cost of the consultation will apply
- any previously outstanding accounts will need to be addressed prior to attending your initial consultation with Women's Health @ Hawkins.

**Requests for appointments where these boxes are not ticked may not be offered an appointment.

Office use only:

Date referral received: _____	Patient details entered into BP: <input type="checkbox"/>
Patient contacted: <input type="checkbox"/>	WHC allocated to patient record #: <input type="checkbox"/>
Left message: <input type="checkbox"/> Appt booked: <input type="checkbox"/>	Referral scanned into system: <input type="checkbox"/>
Details:	

Dr: _____