

# Victorian Perinatal Emergency Referral Service

## Feedback – Receiving Hospital



*Please fax this form to (03) 9344 3371*

Patient Name \_\_\_\_\_ Date of Consultation     /     /

Receiving hospital \_\_\_\_\_

Receiving hospital clinician \_\_\_\_\_

**Provisional Diagnosis** \_\_\_\_\_ **Gestation** \_\_\_\_\_

### **Feedback:**

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Phone Number: (     ) \_\_\_\_\_

Do you wish to be contacted to discuss this matter further?            Yes            No