Please save this form to your computer, then complete it and click submit to send via email.

IDENTIFY

COUNTRY HEALTH CONNECT

Government of South Australia
SA Health

Community Health Service

REFERRAL FORM

UR/MRN: _____

Surname: _____

Given Names: _____

Preferred Name: _____

DOB: _____ **Gender:** _____

SITUATION

Date of Referral:	**Time:**		**Referring Agency/Health Unit:**		
Client Aware of Referral: ☐ Yes ☐ No			**Form Completed By:**		
Client Consent Given: ☐ Yes ☐ No			**Position:**		
Guardianship of the Minister: ☐ Yes ☐ No			**Tel:**	**Pager:**	**Fax:**
REFERRING HOSPITAL (***If Referral is from Hospital, please complete below section***):					
Patient Requires: ☐ Inpatient Services ☐ Community Health Services on Discharge					
Admission Date:			**Hospital/Ward:**		
Discharge Date: ☐ Expected ☐ Actual			**Hospital Medical Record #:**		
Follow-Up GP/Outpatient Appointment Date:			**Required Service Start-Date:**		

CLIENT INFORMATION:			**Individual National Health Identifier:**		
Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:					
Marital Status: ☐ Single ☐ Widow ☐ Married ☐ De Facto ☐ Separated ☐ Divorced					
Residential Address:					
Postal Address:					
Accommodation Setting (***eg. Owns Home, Renting – Public, Renting – Private***):					
Home Tel:	**Work Tel:**		**Mobile Tel:**		
Country of Birth:			**Language Spoken at Home:**		
Aboriginal/Torres Strait Islander: ☐ Yes ☐ No			**Interpreter Required:** ☐ Yes ☐ No		
Private Health Insurance: ☐ Hospital Cover ☐ Extras Cover ☐ Ambulance Cover ☐ No Cover					
GP/Specialist/Medical Clinic:			**Allergies/Infectious Conditions** (***specify below***):		
Pre-Existing GP Management Plan: ☐ Yes ☐ No					
Pre-Existing Team Care Arrangement: ☐ Yes ☐ No			**Known Hazards for Home Visits** (***specify below***):		
Pre-Existing Service Providers:					
Medicare Card #:			**Individual Reference #:**	**Expiry:**	
Concession Card #:			**Type** (***eg. Aged, DVA***):	**Expiry:**	
National Disability Insurance Scheme #:			**Compensable:** ☐ Yes ☐ No		
Client Lives: ☐ Alone ☐ With Family ☐ Other:			**Client Has Carer:** ☐ Yes ☐ No		
Advance Care Directive: ☐ Yes ☐ No			**Carer Lives with Client:** ☐ Yes ☐ No		
EMERGENCY CONTACT/GUARDIAN/CARER/SUBSTITUTE DECISION-MAKER:					
Name:			**Relationship:**		
Address:					
Home Tel:	**Work Tel:**		**Mobile Tel:**		

BACKGROUND / ASSESSMENT REQUEST

MEDICAL HISTORY (***Primary and Secondary Diagnosis/Current or recent Hospital admission details***):

PRESENTING PROBLEM:

MANAGEMENT/CARE REQUESTED (***Reason for Referral, eg. Physiotherapy***):

Attached: ☐ Medication Authority ☐ Medication List ☐ Investigation

Submit

←Click the "Submit" button to lodge your referral via email OR
←Fax completed form to 08 8115 5734 Tel. 08 8638 1100 or 1800 003 307
Email:Health.YNLHNMidNorthCommunityHealthReferrals@sa.gov.au

OFFICE USE ONLY:
YNLHN

Please save this form to your computer, then complete it and click submit to send via email.