COUNTRY HEALTH CONNECT

Government of South Australia
SA Health

Community Health Service

REFERRAL FORM

Surname: _____

Given Names: _____

Preferred Name: _____

DOB: _____ **Gender:** _____

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:**

IDENTIFY

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 (NDIS) # (*if applicable*):			
Client Lives: ☐ Alone ☐ With Family ☐ Other:		**Client Has Carer:** ☐ Yes ☐ No	
Advance Care Directive: ☐ Yes ☐ No		**Carer Lives with Client:** ☐ Yes ☐ No	

SITUATION

EMERGENCY CONTACT/GUARDIAN/CARER/SUBSTITUTE DECISION-MAKER:		
Name:		**Relationship:**
Address:		
Home Tel:	**Work Tel:**	**Mobile Tel:**
REFERRING HOSPITAL (*If Referrals 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:**

BACKGROUND/ASSESSMENT REQUEST

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

PRESENTING PROBLEM:

MANAGEMENT/CARE REQUESTED (*Reason for Referral*): **Attached:** ☐ Medication Authority ☐ Medication List ☐ Investigation

Submit

← ***Click the "Submit" button to lodge your referral via email***
OR Fax completed form to 08 8721 1461
Tel. 1800 003 307

OFFICE USE ONLY:
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