



**COUNTRY
HEALTH
CONNECT**



Community Health Service
REFERRAL FORM

Surname: _____
 Given Names: _____
 Preferred Name: _____
 DOB: _____ Gender: _____

Date of Referral:	Time:	Referring Agency/Health Unit:		
Client Aware of Referral:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Form Completed By:		
Client Consent Given:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Position:		
Guardianship of the Minister:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tel:	Pager:	Fax:

CLIENT INFORMATION		Individual National Health Identifier:	
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other:			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widow <input type="checkbox"/> Married <input type="checkbox"/> De Facto <input type="checkbox"/> Separated <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter Required:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Health Insurance: <input type="checkbox"/> Hospital Cover <input type="checkbox"/> Extras Cover <input type="checkbox"/> Ambulance Cover <input type="checkbox"/> No Cover			
GP/Specialist/Medical Clinic:		Allergies/Infectious Conditions (specify below):	
Pre-Existing GP Management Plan:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pre-Existing Team Care Arrangement:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pre-Existing Service Providers:		Known Hazards for Home Visits (specify below):	
Medicare Card #:	Individual Reference #:	Expiry:	
Concession Card #:	Type (eg. Aged, DVA):	Expiry:	
National Disability Insurance Scheme (NDIS) # (if applicable):			
Client Lives: <input type="checkbox"/> Alone <input type="checkbox"/> With Family <input type="checkbox"/> Other:		Client Has Carer:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Advance Care Directive:		Carer Lives with Client:	<input type="checkbox"/> Yes <input type="checkbox"/> No

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: <input type="checkbox"/> Inpatient Services <input type="checkbox"/> Community Health Services on Discharge			
Admission Date:		Hospital/Ward:	
Discharge Date:		<input type="checkbox"/> Expected <input type="checkbox"/> Actual	
Hospital Medical Record #:		Hospital Medical Record #:	
Follow-Up GP/Outpatient Appointment Date:		Required Service Start-Date:	

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

← Click the "Submit" button to lodge your referral via email
 OR Fax completed form to 08 8580 2550
 Tel. 1800 003 307

OFFICE USE ONLY:
R

IDENTIFY

SITUATION

BACKGROUND/ASSESSMENT REQUEST