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 8644 5192
Tel. 1800 003 307

OFFICE USE ONLY:
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