Government of South Australia
SA Health

REFERRAL FORM

Southern Adelaide Local Health Network

GEM@Home

Out reach - Case Management ☐

In reach – In patient in patient home ☐

Affix Patient Label

NAME: .....

DOB: .....

Date of Referral .....

Client No. .....

Details of person being referred

Title: (Mr. Mrs. Miss Ms.)

Surname: .....

Given name(s): .....

Preferred name(s): .....

Sex: ☐ Male ☐ Female ☐ Not stated

DOB: / / ☐ Estimate Age: .....

Usual Address: .....

..... Postcode: .....

Postal Address: .....

..... Postcode: .....

Phone (Home): .....

Marital status

☐ Never married ☐ Widowed ☐ Divorced

☐ Separated ☐ Married/defacto ☐ Not known

Accommodation setting

☐ Home Owner ☐ Private Rental ☐ Public Rental

☐ ILU ☐ Boarding House

☐ Other .....

Usual Living Arrangements

☐ Lives alone ☐ Lives with Family

☐ Lives with others ☐ Not stated

Pension Type .....

Pension Number.....

Health insurance ☐ yes ☐ no ☐ unknown

Ambulance cover ☐ yes ☐ no ☐ unknown

Country of birth .....

Primary language .....

Indigenous status ☐ yes ☐ no ☐ not stated

☐ Aboriginal, not TSI ☐ TSI, not Aboriginal ☐ Both

Interpreter required ☐ yes ☐ no ☐ unknown

If yes, details .....

Details of person making referral

Name: .....

Organisation: .....

Relationship to Client: .....

Phone: .....

Client aware of referral: ☐ yes ☐ no

If No, reason: .....

If referred by hospital: Ward .....

Admission Date: ..... Discharge date: .....

Client's Key Contact

Name: .....

Is this person the client's carer? ☐ yes ☐ no

To be at assessment? ☐ yes ☐ no

Does this person reside with the client? ☐ yes ☐ no

If no, Address: .....

Phone Numbers

Home: .....

Work: .....

Mobile: .....

E-mail: .....

Relationship to client

☐ Spouse/partner ☐ Daughter/son ☐ Parent

☐ Sibling ☐ Other relative ☐ Friend

☐ Not stated ☐ Other

Comments: .....

Carer Availability

☐ Has carer ☐ Has no carer ☐ Not stated

Carer Relationship

☐ Wife/Female Partner ☐ Husband/Male Partner

☐ Daughter ☐ Son

☐ Other: .....

Phone: 74250346 Health.SALHNGEMatHome@sa.gov.au **FAX: 81241435**

Please ensure HOME VISIT RISK ASSESSMENT IS COMPLETED OR ATTACHED

Carer Residency

☐ Co-Resident ☐ Non-Resident ☐ Not stated

Affix Patient Label

NAME: .....

DOB .....

GP

Name: .....

Address: .....

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Phone (work): .....

E-mail: .....

Comments: .....

Reason for Referral to the GEM@HOME: .....

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Medical History/Social History: .....

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Presenting problems and issues: .....

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Risks or Hazards in the home (eg animals, smoker, behavioural issues):

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Current Services

Service Type	Organisation / Contact Details

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