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COUNTRY HEALTH CONNECT

Government of South Australia
SA Health

LCLHN Community Health Service

REFERRAL FORM

UR/MRN: _____
Surname: _____
Given Names: _____
Preferred Name: _____
DOB: _____ **Gender:** _____

IDENTIFY

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 Health.LCLHNIntake@sa.gov.au
← OR Fax completed form to 08 8124 4685
Tel. 08 8721 1460

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