Please save this form to your computer, then complete it and click submit to send via email.

IDENTIFY

SITUATION

BACKGROUND / ASSESSMENT REQUEST

COUNTRY HEALTH CONNECT

Government of South Australia
SA Health

OFFICIAL

FUNLHN Community Health Service

REFERRAL FORM

UR/MRN: _____

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:**
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:**	

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
←HealthCHSACountryHlthConnectFUNReferrals@sa.gov
Tel. 1800 944 912

OFFICE USE ONLY:
FUN

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