

IDENTIFY



**COUNTRY
HEALTH
CONNECT**



Community Health Service

REFERRAL FORM

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

SITUATION

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:
REFERRING HOSPITAL (If Referral 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 #:	
Follow-Up GP/Outpatient Appointment Date:		Required Service Start-Date:		

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	Known Hazards for Home Visits (specify below):	
Pre-Existing Team Care Arrangement:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pre-Existing Service Providers:				
Medicare Card #:		Individual Reference #:		Expiry:
Concession Card #:		Type (eg. Aged, DVA):		Expiry:
National Disability Insurance Scheme #:		Compensable:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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:		<input type="checkbox"/> Yes <input type="checkbox"/> No	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:

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: <input type="checkbox"/> Medication Authority <input type="checkbox"/> Medication List <input type="checkbox"/> Investigation

← Click the "Submit" button to lodge your referral via email
 OR Fax completed form to 1800 771 211
 Tel. 1800 003 307 Email: Health.CountryReferralUnit@sa.gov.au



OFFICE USE ONLY:
 CRU-BHF