



**COUNTRY  
HEALTH  
CONNECT**



Community Health Service  
**REFERRAL FORM**

Surname: \_\_\_\_\_  
 Given Names: \_\_\_\_\_  
 Preferred Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

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: _____

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

<b>EMERGENCY CONTACT/GUARDIAN/CARER/SUBSTITUTE DECISION-MAKER:</b>		
Name:	Relationship:	
Address:		
Home Tel:	Work Tel:	Mobile Tel:
<b>REFERRING HOSPITAL (If Referrals is from Hospital, please complete below section):</b>		
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:	

**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

← Click the "Submit" button to lodge your referral via email  
 OR Fax completed form to 1800 771 211  
 Tel. 1800 003 307

**OFFICE USE ONLY:**  
 CRU

IDENTIFY

SITUATION

BACKGROUND/ASSESSMENT REQUEST