

Referral Date:	
Community to be seen in:	

Health Services
East Coast (EC) / Central West (CW) / North West (NW) / Lower Gulf (LG)

<input type="checkbox"/> Aboriginal Health Practitioner (NW)	<input type="checkbox"/> Drugs and Alcohol (LG)	<input type="checkbox"/> Podiatrist (CW, EC, NW, LG)
<input type="checkbox"/> Carer Support (NW)	<input type="checkbox"/> Exercise Physiologist (CW, EC, NW, LG)	<input type="checkbox"/> Psychologist (EC)
<input type="checkbox"/> Child & Youth Mental Health (LG, NW)	<input type="checkbox"/> Family Wellbeing Support (NW, LG)	<input type="checkbox"/> Speech Pathologist (NW, LG)
<input type="checkbox"/> Continence Advisor (CW, EC, NW, LG)	<input type="checkbox"/> Mental Health Professional (NW, LG, EC)	<input type="checkbox"/> School Attendance (LG)
<input type="checkbox"/> Dementia Advisor (NW, LG)	<input type="checkbox"/> NDIS Info & Support (CW, LG, NW)	<input type="checkbox"/> Transition Officer (LG)
<input type="checkbox"/> Diabetes Educator (CW, NW, LG)	<input type="checkbox"/> Occupational Therapist (EC, NW, LG, CW)	<input type="checkbox"/> Wellbeing Support (LG, NW)
<input type="checkbox"/> Dietitian (CW, NW, LG)	<input type="checkbox"/> Physiotherapist (CW, EC, LG, NW)	<input type="checkbox"/> Youth Wellbeing Support (LG)
Other: _____		

REFERRAL SOURCE

Full Name	Organisation	Address	Phone

CLIENT DETAILS

Full Name	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Address	Ethnicity	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal and Torres Strait Islander <input type="checkbox"/> Australian South Sea Islander <input type="checkbox"/> Other:
DOB	Preferred Language	
Phone	Mobile	
Email		
Medicare No. & IRN	Pension No. & Expiry	
Medicare Expiry Date	Individual Health Identifier	
NDIS Number (Plan Attached)	My Aged Care Number	
General Practitioner (GP)	(GP) Contact	
Known Allergies/Alerts		

NEXT OF KIN / EMERGENCY CONTACT

Name	Address	Relationship	Phone

REASON FOR REFERRAL*

**If this referral is being made under a Medicare Allied Health Initiative, DVA or WorkCover please attach the relevant Medicare, DVA or WorkCover referral form, and a copy of the GP Management Plan, Team Care Arrangements or Mental Health Treatment Plan if applicable.*

Medical Conditions	
Medications	

CLIENT CONSENT

I _____ consent to this referral being made, for the creation and maintenance of a file and for the sharing of my personal information with NWRH and other Health care providers for the purpose of actioning this referral.

Client / Parent / Guardian to sign:

Signature: _____ Name: _____ Date: _____

Verbal Consent obtained