NWRH Referral Form

Fax: 61744220079
Email: centralintake@nwrh.com.au

Referral Date:	
Community to be seen in:	

Health Services

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

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

REFERRAL SOURCE

Full Name		**Organisation**	
Address		**Phone**	

CLIENT DETAILS

Full Name		**Gender**	☐ Male ☐ Female ☐ Other
Address		**Ethnicity**	☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Australian South Sea Islander ☐ 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