Peninsula Health

ACCESS REFERRAL

Fax: 03 9125 5862
Phone: 1300 665 781
(Internal) Email: 'Access Referrals'
(External website)
https://www.peninsulahealth.org.au/services/access-referrals/

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....
Please fill in if no Patient Label available

App.28/7/25 Print Code:12736

PHF151650Y

Address: .....

Landline: ..... Mobile: ..... Preferred contact method: Landline/Mobile/Email/Other .....

Email: .....

Country of Birth: ..... Preferred Language: ..... Interpreter: ☐ Yes ☐ No

Aboriginal/Torres Strait Islander: ☐ Yes ☐ No ☐ Not Stated Refugee / Asylum Seeker Status: ☐ Yes ☐ No

Compensable category: ☐ WorkCover ☐ TAC ☐ NDIS ☐ DVA ☐ Overseas visitor ☐ N/A

Medicare No: ..... Medicare IRN: ..... Sex at Birth: ☐ Male ☐ Female ☐ Other

NDIS Identifier: ..... Pension / Health Care / DVA Gold Card No. .....

GP Name: ..... GP Phone: .....

GP Address: .....

Client has consented: ☐ Yes ☐ No Who to contact regarding this referral?: ☐ Client ☐ Other Contact Person

Other Contact Person: ..... Phone: ..... Relationship: .....

Service Referred to: **Practitioner:** .....

☐ Aboriginal Health Services	☐ Continence	☐ Geriatric Medicine Clinic (GMC)	☐ Physiotherapy
☐ Advance Care Planning	☐ Counselling	☐ Homelessness & Health Outreach Service	☐ Podiatry
☐ Agestrong	☐ Diabetes Education	☐ Integrated Pain Service (PHIPS)	☐ Pulmonary Rehab
☐ Alcohol & other Drugs	☐ Dietetics	☐ Lymphoedema	☐ Sexual Health
☐ Cancer Rehab	☐ Exercise Physiology	☐ Movement Disorder Program	☐ Social Support Group
☐ Cardiac Services	☐ Falls Prevention	☐ NDIS services	☐ Speech Pathology
☐ Carer Health and Wellbeing Service		☐ Occupational Therapy	
☐ Children's Services		☐ Other	
☐ Cognition, Dementia & Memory Service (CDAMS)		.....	
☐ Community Care (HARP / RIR / PAC)		.....	

Current Inpatient: ☐ Yes ☐ No Anticipated Discharge Date:...../...../.....

☐ Home Based ☐ Centre Based ☐ High Priority ☐ Routine Priority

Reason for Referral: .....

.....

Diagnosis / Medical History / Recent Surgery: .....

.....

Communication	**Physical Function**	**Social**	**Current Services**	**Risks**
☐ Hearing impaired	☐ Independent	☐ Lives Alone	☐ Council	☐ Behavioural Concern
☐ Vision impaired	☐ Requires Prompting	☐ Lives with family	☐ NDIS Plan	☐ Allergies
☐ Speech impaired	☐ Requires Assistance	☐ Lives with others	☐ Child Protection	☐ Other (list)
☐ Cognitive impairment	☐ Walks with aids	☐ Out of home < 18yrs	☐ **Home care package**	
☐ Reduced insight	☐ Falls with harm history	☐ Lives in Aged care Fac.	☐ Level 1/2 ☐ Level 3/4	
☐ Low literacy	☐ Incontinent		☐ Other	

Referrer Name: ..... Signature: ..... Desig / Provider No. .....

Organisation Name / Address: .....

Phone: ..... Date: ..... / ..... / .....

ACCESS REFERRAL

MR/151650

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