

ACCESS REFERRAL**Fax: 03 9125 5862****Phone: 1300 665 781**

(Internal) Email: 'Access Referrals'

UR NUMBER

SURNAME

GIVEN NAMES

DATE OF BIRTH

Please fill in if no Patient Label available

App.5/8/26 Print Code:12736

Address (Required):

Daytime telephone (Required):

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

Email:

Country of Birth: Preferred Language: Interpreter: ☐ Yes ☐ NoAboriginal/Torres Strait Islander: ☐ Yes ☐ No ☐ Not Stated Refugee / Asylum Seeker Status: ☐ Yes ☐ NoCompensable category: ☐ WorkCover ☐ TAC ☐ NDIS ☐ DVA ☐ Overseas visitor ☐ Other ☐ N/ASex at Birth: ☐ Male ☐ Female ☐ Other Gender:

Medicare No: IRN: My Aged Care AC No:

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

GP Name: GP Phone:

GP Address:

Is the client aware of the referral? ☐ Yes ☐ NoClient has consented: ☐ Yes ☐ No Who to contact regarding this referral?: ☐ Client ☐ Other Contact Person

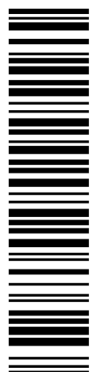
Other Contact Person: Relationship:

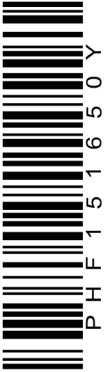
Phone (Required): Interpreter required: ☐ Yes ☐ No**Service Referred to:**

(Required)

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 (PIPS) | ☐ Pulmonary Rehab |
| ☐ Alcohol & other Drugs | ☐ Dietetics | ☐ Lymphoedema | ☐ Seniors Lifestyle Victoria |
| ☐ Cancer Rehab | ☐ Exercise Physiology | ☐ Movement Disorder Program | ☐ Sexual Health |
| ☐ Cardiac Services | ☐ Falls Prevention | ☐ Occupational Therapy | ☐ Social Support Group |
| ☐ Children's Services | ☐ Family Violence (MBCP and KFS) | ☐ Speech Pathology | |
| ☐ Cognition, Dementia & Memory Service (CDAMS) | ☐ Other | | |
| ☐ Community Care (HARP / RIR / PAC) | | | |

Current Inpatient: ☐ Yes ☐ No Anticipated Discharge Date:/...../.....☐ Home Based☐ Centre Based☐ High Priority☐ Routine Priority



Bayside Health Peninsula

ACCESS REFERRAL cont.

UR NUMBER
SURNAME
GIVEN NAMES
DATE OF BIRTH
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Reason for Referral:
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.....
.....

Diagnosis / Medical History / Recent Surgery:
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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	☐ Support at Home, if yes specify level:	
☐ Reduced insight	☐ Falls with harm history	☐ Lives in Aged care Fac.		
☐ Low literacy	☐ Incontinent	☐ Other		

Referrer Name (Required)	Signature	Designation	Provider No
Organisation Name / Address		Email	
Daytime phone (Required)	Fax	Date	