

Peninsula Health

ACCESS REFERRAL

Fax: 9784 2309

Phone: 1300 665 781

(Internal) Email: 'Access Referrals'

(External website): www.peninsulahealth.org/access-referrals/

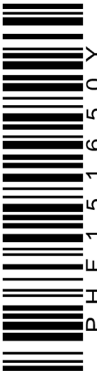
UR NUMBER

SURNAME

GIVEN NAMES

DATE OF BIRTH Gender

Please fill in if no Patient Label available App.4/6/19 Print Code:12736



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Address: Phone:

Email:

Other Contact Person: Phone: Relationship

Preferred contact method: Phone / SMS / email / other

Country of Birth: Preferred Language:

Aboriginal / Torres Strait Islander: Yes / No / Not Stated Refugee Status? Yes / No Interpreter required? Yes / No

Medicare No. Card type (circle): Pension / Health Care / DVA Gold Card No.

GP Name: GP Phone:

GP Address:

Service Referred to:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Aboriginal Health Services | <input type="checkbox"/> Continence | <input type="checkbox"/> Lymphoedema | <input type="checkbox"/> QUIT Smoking Support |
| <input type="checkbox"/> Advance Care Planning | <input type="checkbox"/> Counselling | <input type="checkbox"/> MI Health (Homelessness) | <input type="checkbox"/> Sexual Health |
| <input type="checkbox"/> Agestrong | <input type="checkbox"/> Diabetes Education | <input type="checkbox"/> Movement Disorder Program | <input type="checkbox"/> Social Support Group |
| <input type="checkbox"/> Cancer Rehab | <input type="checkbox"/> Dietetics | <input type="checkbox"/> NDIS Coordinator | <input type="checkbox"/> Social Work (CRP) |
| <input type="checkbox"/> Cardiac Services | <input type="checkbox"/> Exercise Physiology | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Children's Services | <input type="checkbox"/> Falls Prevention | <input type="checkbox"/> Podiatry | |
| <input type="checkbox"/> Children's NIDIS Services | <input type="checkbox"/> Feeding Clinic | <input type="checkbox"/> Physio | |
| <input type="checkbox"/> Ingegrated Pain Service (PHIPS) | <input type="checkbox"/> LIFE Plus | <input type="checkbox"/> Pulmonary Rehab | |
| <input type="checkbox"/> Cognition, Dementia & Memory Service (CDAMS) | <input type="checkbox"/> Other | | |
| <input type="checkbox"/> Community Care (HARP / RIR / PAC) | | | |

Current Inpatient Yes No Anticipated Discharge Date: / /

Contact should be made with: Client Other contact person Clients consent to referral Yes No

Home Based Centre Based Urgent Routine

Reason for Referral:
.....
.....
.....

Diagnosis / Medical History:
.....

Communication	Physical Function	Social	Current Services	Risks
<input type="checkbox"/> Hearing impaired	<input type="checkbox"/> Independent	<input type="checkbox"/> Lives Alone	<input type="checkbox"/> Council	<input type="checkbox"/> Behavioural Concern
<input type="checkbox"/> Vision impaired	<input type="checkbox"/> Requires Prompting	<input type="checkbox"/> Lives with family	<input type="checkbox"/> NDIS Plan	<input type="checkbox"/> Allergies
<input type="checkbox"/> Speech impaired	<input type="checkbox"/> Requires Assistance	<input type="checkbox"/> Lives with others	<input type="checkbox"/> Private Services	<input type="checkbox"/> Other (list)
<input type="checkbox"/> Cognitive impairment	<input type="checkbox"/> Walks with aids	<input type="checkbox"/> Out of home < 18yrs	<input type="checkbox"/> Child Protection
<input type="checkbox"/> Reduced insight	<input type="checkbox"/> Falls with harm history		<input type="checkbox"/> Home care package
<input type="checkbox"/> Low literacy	<input type="checkbox"/> Incontinent		<input type="checkbox"/> Other

Referrer Name: Signature: Desig / Provider No.

Organisation Name / Address:

Phone: Date: / /

4/6/19 Print Code:12736 Ref Link / Allanbys / GP Liaison

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MR/151650