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

PHF151650Y

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:

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

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: .....

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Diagnosis / Medical History: .....

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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	☐ Private Services	☐ Other (list)
☐ Cognitive impairment	☐ Walks with aids	☐ Out of home < 18yrs	☐ Child Protection	.....
☐ Reduced insight	☐ Falls with harm history		☐ Home care package	.....
☐ Low literacy	☐ Incontinent		☐ Other	.....

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

Organisation Name / Address: .....

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

ACCESS REFERRAL

MR/151650

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