



Central West
5/19 Duck Street
PO Box 256
LONGREACH QLD 4730



Telephone: (07) 4652 7100
Facsimile: (07) 4658 3630
Website: www.nwqphc.com.au

REFERRAL FORM

Referral to NWQPHC:	<input type="checkbox"/> Physiotherapist	<input type="checkbox"/> Speech Pathologist	<input type="checkbox"/> Personal Trainer
	<input type="checkbox"/> Podiatrist	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Ambulatory Blood Pressure
	<input type="checkbox"/> Dietitian	<input type="checkbox"/> Continence Advisor	<input type="checkbox"/> Sleep Studies
	<input type="checkbox"/> Diabetes Educator	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Care Coordinator

Referral source:	Name:
	Organisation:
	Contact Details:

Client details:	Title:	<input type="checkbox"/> Male / <input type="checkbox"/> Female
	Given Name:	
	Surname:	
	DOB:	<input type="checkbox"/> ATSI / <input type="checkbox"/> Other
	Address:	
	Telephone:	Mobile:
	Email/Fax:	
	Next of Kin:	Name: Relationship: Telephone:

Patient to be seen in:	<i>(Please nominate the Central West Queensland town where the patient is to be seen)</i>
-------------------------------	---

Reason for referral:	<i>(Please provide a brief summary of the patient's condition. Attach relevant pathology/reports as required)</i>
-----------------------------	---

Medical conditions:	
----------------------------	--

Known allergies:	
-------------------------	--

Additional information:	
--------------------------------	--

HACC service:	Has ONI been completed or attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
----------------------	--

CLIENT CONSENT:

I authorise and grant access to my personal information to all North and West Queensland Primary Health Care employees for any lawful purpose associated with the provision of services.

Client/ Parent/ Guardian

Name: _____ Signature: _____ Date: _____

Referring Agent

Name: _____ Signature: _____ Date: _____