

REFERRAL FORM

Phone (Freecall): 1800 221 131

Phone: 07 4749 4615 Fax: 07 4743 4858

North West Office: 53 Enid Street, PO Box 1127, Mount Isa



REFERRAL DATE: / /

Discipline	<input type="checkbox"/> Podiatrist	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Psychologist
	<input type="checkbox"/> Dietitian	<input type="checkbox"/> Physiotherapist	<input type="checkbox"/> Speech Pathologist
	<input type="checkbox"/> Diabetes Educator	<input type="checkbox"/> Continence Adviser	<input type="checkbox"/> Dementia Adviser

REFERRAL SOURCE (Name & Organisation & contact details)	Client Title:
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DOB: / /	Surname:
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<input type="checkbox"/> Female <input type="checkbox"/> Male	Client Address:
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Tel No:	Mobile:
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Client to be seen in: Mornington Island Bentinck Island Doomadgee Burketown Normanton Karumba Gregory / Biddungu Mount Isa	Boulia Dajarra Urandangi Camooweal Cloncurry Julia Creek McKinlay	Other Contact (Email/Fax):
		Best time to contact client:
		Preferred Language:
		Interpreter Required: YES / NO
		Next of kin contact details

Ethnicity:
<input type="checkbox"/> Aboriginal
<input type="checkbox"/> Torres Strait Isl.
<input type="checkbox"/> Other

Name:
Relationship:
Telephone:

Reason for Referral (include relevant blood results/pathology/reports if required):

Medical Conditions:

Medications:

Known Allergies:

Additional information / Special needs / Other current service providers:

HACC Service: Has ONI been completed or attached? Yes No

CLIENT CONSENT NWQPHC OFFICE USE ONLY

Do you agree to the creation and maintenance of a file and for NWQPHC staff talking about your health care needs with each other and other health professionals (e.g. GPs) where relevant?

Yes No

Do you agree to your medical information being used for research purposes? (with your name and personal details removed)

Yes No

Are there any people / organisations you do **not** want NWQPHC to talk to about your health care needs. Please state:

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 the services.

Client / Parent / Guardian to sign:

Signature:..... Name:..... Date:.....

NWQPHC service provider to complete:
 I have discussed the above consent statements with..... (client / parent / guardian) face to face / over phone (delete whichever does not apply) and have completed the information as directed by them.

Signature:..... Name:..... Date:.....