Peninsula Health

ACCESS REFERRAL

Fax: 9784 2309
Phone: 1300 665 781

UR NUMBER ....
SURNAME ....
GIVEN NAMES ....
DATE OF BIRTH .... Sex M / F / Other
MARITAL STATUS ....
Please fill in if no Patient Label available

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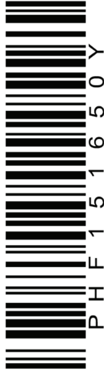

Address: .... Phone ....

Emergency Contact Person: .... Phone .... Relationship ....

Country of Birth .... Preferred Language ....

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

Pension No. .... Medicare No. .... DVA No. .... Card: Gold / White / Other

GP Name: .... GP Phone: ....

GP Address: ....

Service Referred to:

- ☐ Advance Care Planning
- ☐ Agestrong
- ☐ Cardiac Services
- ☐ Children's Services
- ☐ Chronic Pain Management Service
- ☐ Cognition, Dementia & Memory Service (CDAMS)
- ☐ Continence
- ☐ Counselling
- ☐ Diabetes Education
- ☐ Dietetics
- ☐ Drug & Alcohol
- ☐ Exercise Physiology
- ☐ Falls Prevention
- ☐ HARP
- ☐ Mobile Integrated Health
- ☐ Movement Disorders Program
- ☐ Occupational Therapy
- ☐ Podiatry
- ☐ Planned Activity Group
- ☐ Physio
- ☐ Post-Acute Care (PAC)
- ☐ Pulmonary Rehab
- ☐ Quit Smoking Support
- ☐ Residential In-Reach
- ☐ Social Work
- ☐ Speech
- ☐ Youth Team
- ☐ Other ....

Is the Client aware of the referral and has consent been given? Yes ☐ No ☐ Anticipated Discharge Date: .... / .... / ....

Contact should be made with: ☐ Client ☐ Emergency contact person

☐ Home Based ☐ Centre Based ☐ Urgent ☐ Routine

Reason for Referral: ....

....

....

....

Current Diagnosis / issues ....

....

Medical History: ....

....

....

Communication	**Physical Function**	**Social**	**Current Services**	**Risks**
☐ Hearing impaired	☐ Independent	☐ No Identified Supports	☐ Council / Private Services	☐ Behavioural Concern
☐ Vision impaired	☐ Requires Prompting	☐ Lives Alone	☐ Home care package	☐ Allergies
☐ Speech impaired	☐ Requires Assistance	☐ Family Support	(Level 1 - 2) ☐	☐ Other (list)
☐ Cognitive impairment	☐ Walks with aids	☐ Other Supports	(Level 3 - 4) ☐	....
☐ Reduced insight	☐ Falls with harm history		☐ Other	....
	☐ Incontinent			....

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

Organisation Name: ....

Address: ....
.... Phone: .... Date: ....

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