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| **Title of form:** | **Client referral form** |

**Reminder:** referrals to aged care services for people 65+ are via My Aged Care. Call 1800 200 422.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name\*** | | | | Click here to enter text. | | | | | | | |
| **Address\*** | | | | Click here to enter text. | | | | | | | |
|  | | | | **Suburb\*** | Click here to enter text. | | | **Postcode\*** | Click here to enter text. | | |
| **Contact number\*** | | | | **Phone** | Click here to enter text. | | | **Mobile** | Click here to enter text. | | |
| **Date of birth\*** | | | | Click here to enter text. | | | | | | | |
| **Country of birth** | | | | Click here to enter text. | | | | | | | |
| **Preferred language** | | | | Click here to enter text. | | | | | | | |
| **Are you Aboriginal and/or Torres Strait Islander?** | | | | | | | | | | | |
|  | Aboriginal |  | Torres Strait Islander | | |  | Aboriginal & Torres Strait Islander | | |  | N/A |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Client emergency contact** | | | | |
| **Name\*** | Click here to enter text. | | | |
| **Contact number\*** | **Phone** | Click here to enter text. | **Mobile** | Click here to enter text. |
| **Relationship\*** | Click here to enter text. | | | |

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| **GP details** | | | | | | | |
| **Name** | | Click here to enter text. | | | | | |
| **Practice address** | | Click here to enter text. | | | | | |
| **Contact number** | | Click here to enter text. | | | | | |
| **Service requested\*** | | | | | | | |
|  | Asthma clinic |  | Dietetics |  | Diabetes education |  | Little feet & limbs clinic |
|  | Podiatry |  | Stop smoking |  | Occupational therapy |  | Speech pathology |
|  | Physiotherapy |  | | | | | |
| **Reason why referral is**  **required\*** | | Click here to enter text. | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer details or person completing this form** | | | |
| **Name** | Click here to enter text. | **Organisation or relationship** | Click here to enter text. |
| **Contact number** | Click here to enter text. | **Email** | Click here to enter text. |

**Send completed referral form to:** **\*Fields must be completed**

Fax 03 9495 2599

**Important:** please be mindful of client privacy and Australian privacy laws when deciding how best to send this information.