FMDHS 004 050

Maryborough District Health Service **Primary and Preventative Health** **CR-REF1 SELF REFERRAL**	UR No …… Surname ……..…… Given Names ……..…… DOB ……. GP ……..…..…….. **AFFIX PATIENT LABEL HERE**

☐ I am making this referral for myself. ☐ I am making this referral on behalf of someone.

Name and relationship of person making referral:_____

☐ I am over the age of 18 years and consent to this referral.

☐ I am under the age of 18 years. Parent or guardian consent gained: ☐ Yes ☐ No

☐ Verbal consent gained ☐ Written consent (*signature)*: _____

PERSONAL DETAILS

Title		**Gender**	
Surname		**Given Names**	
Date of Birth		**Home Phone Number**	
Email		**Mobile Number**	
Address			

GP DETAILS

Name		**Clinic**	
Phone Number		**FAX**	
Address			

As a public health service we are required to collect the following information.

CONSUMER DETAILS

Country of Birth		**Language Spoken**	
Marital Status		**Are you a refugee?**	☐ Yes ☐ No Year:
Are you of Aboriginal or Torres Strait Islander origin?	☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No	**Accommodation**	☐ Independent living ☐ Homeless ☐ Hostel/Nursing home ☐ Supported
Living Arrangement	☐ Living alone ☐ Living with family ☐ Living with others ☐ Has a carer	**Consent**	To send SMS reminder ☐ Yes ☐ No To leave voicemail ☐ Yes ☐ No
Employment Status		**Legal proceedings in place**	☐ Yes ☐ No
Medicare Number		**Expiry Date**	
Health Care Card		**Expiry Date**	
Pension Card		**Expiry Date**	
DVA Card		**Expiry Date**	
NDIS Participant Number		**My Aged Care Number**	

EMERGENCY CONTACT DETAILS / NEXT OF KIN			
Name		**Relationship**	
Date of Birth		**Phone Number**	
Address			
Are you of Aboriginal or Torres Strait Islander origin?	□ Yes, Aboriginal □ Yes, Torres Strait Islander □ No		

REFERRAL DETAILS		
Who would you like to see?		
□ Occupational Therapy	□ Physiotherapy	□ Speech Pathology
□ Dietitian	□ Exercise Physiology	□ Diabetes Education
□ Social Work/Counselling	□ Alcohol and Other Drug	□ HARP/HIP
□ Housing	□ Justice Social Worker	□ Planned Activity Group
Other:		
Reason for referral:		
Medical History or Past Procedures:		
Medications:		
Allergies		
□ Yes □ No Details:		
Do you consent to MDHS contacting your GP for further information regarding your referral?		
□ Yes □ No		
Do you consent to MDHS accessing medical imaging?		
□ Yes □ No		

Information collected by:_____ Date:_____

Email completed form: Intake.ComServices@mdhs.vic.gov.au