

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No Year:
Are you of Aboriginal or Torres Strait Islander origin?	<input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> No	Accommodation	<input type="checkbox"/> Independent living <input type="checkbox"/> Homeless <input type="checkbox"/> Hostel/Nursing home <input type="checkbox"/> Supported
Living Arrangement	<input type="checkbox"/> Living alone <input type="checkbox"/> Living with family <input type="checkbox"/> Living with others <input type="checkbox"/> Has a carer	Consent	To send SMS reminder <input type="checkbox"/> Yes <input type="checkbox"/> No To leave voicemail <input type="checkbox"/> Yes <input type="checkbox"/> No
Employment Status		Legal proceedings in place	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> No		

REFERRAL DETAILS**Who would you like to see?**

<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physiotherapy	<input type="checkbox"/> Speech Pathology
<input type="checkbox"/> Dietitian	<input type="checkbox"/> Exercise Physiology	<input type="checkbox"/> Diabetes Education
<input type="checkbox"/> Social Work/Counselling	<input type="checkbox"/> Alcohol and Other Drug	<input type="checkbox"/> HARP/HIP
<input type="checkbox"/> Housing	<input type="checkbox"/> Justice Social Worker	<input type="checkbox"/> Planned Activity Group

Other:

Reason for referral:

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Medical History or Past Procedures:

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Medications:

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Allergies

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
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Do you consent to MDHS contacting your GP for further information regarding your referral?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you consent to MDHS accessing medical imaging?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Information collected by: _____

Date: _____