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 over the age of 65 years and consent to this referral to My Aged Care

☐ 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<br>☐ Yes, Torres Strait Islander<br>☐ No | **Accommodation** | ☐ Independent living<br>☐ Homeless<br>☐ Hostel/Nursing home<br>☐ Supported |
| **Living Arrangement** | ☐ Living alone<br>☐ Living with family<br>☐ Living with others<br>☐ Has a carer | **Consent** | To send SMS reminder<br>☐ Yes ☐ No<br>To leave voicemail<br>☐ 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<br>☐ Yes, Torres Strait Islander<br>☐ 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 | ☐ Well Women's Clinic | ☐ Smoking Cessation |
| ☐ District Nursing | ☐ Aboriginal Hospital Liaison Officer | |
| 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