Southern NSW Local Health District

Facility:

REQUEST FOR COMMUNITY HEALTH AND NON-ADMITTED CARE (CENTRAL INTAKE)

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	

Leave blank - place label here

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

To place a referral, please email the completed form to Central Intake Service:
SNSWLHD-CommunityIntake@health.nsw.gov.au
To speak with a member of the Intake team,
Telephone 1800 999 880 (select option 2)

SERVICE REQUESTED: _____ Date: ____/____/20____

CLIENT DETAILS

Medical Record Number: _____

Family name: _____ Given names: _____

Date of birth: ____/____/_____ Person Sex: ☐ Male ☐ Female ☐ Indeterminate

Usual residential address:

Street: _____ Suburb: _____ Postcode: _____ State: _____

Home telephone: _____ Mobile telephone: _____

Email address: _____

Communication preference: ☐ telephone call ☐ SMS ☐ email

Marital status: ☐ Married ☐ Separated ☐ Never married ☐ Widowed ☐ Divorced ☐ De facto ☐ Unknown

Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown

Country of Birth: _____ Preferred language: _____ Interpreter required? ☐ Yes ☐ No

Medicare eligibility: ☐ Eligible Australian resident ☐ Eligible overseas visitor ☐ Ineligible overseas visitor ☐ Unknown

Medicare card number: |___|___|___|___| |___|___|___|___|___| |___| Ref no. |___| Valid to: _____/_____

DVA card number: _____ Card colour: ☐ Gold ☐ White ☐ Orange

Private health insurance: ☐ Yes ☐ No PHI fund name: _____ Insurance number: _____

Person to contact name: _____ Phone: _____ Relationship: _____

GENERAL PRACTITIONER DETAILS

Usual general practice name: _____

GP Name: _____ Practice email address: _____

Address: _____ Telephone: _____

Facsimile: _____

REFERRER DETAILS

Name: _____ Service: _____

Designation: _____

Telephone: _____

Note: Some Community Health Services are funded by the Commonwealth Home Support Program (CHSP) and a My Aged Care assessment is required.

Would you like the accepting service to determine if the person is eligible for the CHSP? (Applies only to physiotherapy, occupational therapy and community nursing) ☐ Yes ☐ No

Does this person receive a home care package? ☐ Yes ☐ No

PTO - *Please compete the required details to ensure this referral is valid.*

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Reason for referral:

Include sufficient detail about the person to enable effective treatment and care. Include details about current Aged Care Packages and temporary residential address (if applicable).

Use ISBAR to ensure safety in the transfer of care for this person. Identify, Situation, Background, Assessment, Recommendation.

Please attach the following documents with this referral

- ☐ Discharge summary or patient summary
- ☐ Details of treatment and/or investigations relating to the referral reason
- ☐ Current dressing-type, last change date, next change date
- ☐ Current medicines and treatment orders

NO WRITING