

Link Health and Community - Referral Form

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Date of Referral:

Consumer Details:

Consent

- Yes - Consumer consents for referral and information to be given to relevant persons
No - Consumer does not give consent

Family Name: _____

Given Name: _____

Preferred Name/s: _____

Title: _____ Date of Birth: _____

Sex: male / female

Contact Details

Address: _____

Suburb: _____ Post Code: _____

Phone/Mobile: _____

Email: _____

Can we leave a message/send a SMS? Yes / No

Can we send information about our services? Yes / No

Country of Birth: _____

Preferred Language: _____

Interpreter Required: Yes / No

Do you have a Healthcare card? Yes / No

Card Number: _____ Exp: _____

Do you have a carer? Yes / No

Indigenous Status:

- Aboriginal / Torres Strait Islander
 Both Aboriginal & Torres Strait Islander
 NOT Aboriginal or Torres Strait Islander

Who may we list as your additional contact?
(e.g Carer, parent, friend, emergency contact)

Name: _____

Contact Address: _____

Contact Phone Number: _____

Relationship to Consumer: _____

Who do we contact to make an appointment?

- Client / Additional Contact /
 Other: _____

Referral Details:

Referring Person: _____

Organisation: _____

Contact Details: _____

Services Requested:

- Addiction Recovery Services
 Audiology
 Counselling / Family Services
 Diabetes Education
 Dietetics / Nutrition
 Exercise Physiology
 General Practitioner (GP)
 Group Program/s:
 Oral Health
 Occupational Therapy
 Physiotherapy
 Podiatry
 Speech Pathology

Reason for referral: _____

Medical History: _____

Medications: _____

Pathology/Imaging:

- Attached Noted Below: _____

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www.linkhc.org.au