Health
Mid North Coast
Local Health District

Community Health Referral Form

M.R.N. _____

SURNAME _____

OTHER NAMES _____

ADDRESS _____

_____

DATE OF BIRTH _____ M ☐ F ☐

PHONE : H _____ W _____

REFERRED BY _____ DATE: _____

AGENCY _____ PH: _____

LOCAL MEDICAL OFFICER _____

HOSPITAL DISCHARGE DATE _____

WARD _____

NEXT OF KIN _____

RELATIONSHIP _____

Ph: _____

ADDRESS _____

_____

PLEASE FULLY COMPLETE ALL APPLICABLE SECTIONS OF THIS FORM

TO BE ASSESSED BY: Community Nursing ☐ Wound Clinic ☐ Palliative Care ☐ Aged Care ☐ Other _____

Please refer to back page and fax form to appropriate Community Health Program

Phone Notification Made Yes ☐ No ☐ Commencement date requested _____

UNTIL PHONE CONFIRMATION OCCURS THIS REFERRAL CANNOT BE PROGRESSED

CLIENT/CARER/GUARDIAN AWARE OF / AGREE TO REFERRAL YES ☐ NO ☐

Is client of Aboriginal or Torres Islander origin? YES ☐ NO ☐

If yes would the client like to be referred to the Local Aboriginal Medical Clinic? YES ☐ NO ☐

Are there any WH&S concerns for staff associated with this referral? YES ☐ NO ☐ Details

_____

REASON FOR REFERRAL _____

_____

_____

PRESENT MEDICATIONS (including alcohol and other drugs) _____

_____

_____

PAST HISTORY

(Please include : INFECTION YES / NO RECENT SWAB DATE: _____ **OPERATION / PROCEDURES AND DATES)** _____

_____

_____

_____

_____

PLEASE ALSO PROVIDE PROCEDURE SHEET / MEDICATION SHEET AS NECESSARY

OTHER COMMUNITY HEALTH SERVICES INVOLVED/ OTHER RELEVANT INFORMATION _____

_____

_____

INTAKE INFORMATION: Contact Date: Contact Time: Signature:

Relevant Information _____

_____

_____

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