|  |  |
| --- | --- |
| \*25145\*  **ACT Health**  Community Health Intake | **URN:**  **Family name:**  **Given names:**  **Date of Birth:**       **Sex:** |

**Phone:** 6207 9977 **Fax:** 6205 2611

**Is client aware of referral?**   **Consent for database registration**

GP / Specialist Details:

**Name:**       **Address:**

**Phone No:**       **Fax No:**

**Patient/Client/Consumer Details:**

**Title:**       **Given Name:**       **Surname:**

**Gender:**  M  F **Date of Birth:**

**Address:**

**Phone:** Home:       Work:       Mobile:

**Permission to leave message**:  home  mobile  SMS  NOK

**Medicare Number:**

***If client is staying with relative please include contact no. and visit address of relative:***

**Address:**       **Ph:**

**Funding Type**:  Aged pension  Health Care Card  Vets Affairs – GOLD

Commonwealth Home Support Program (CHSP)

National Disability Insurance Scheme (NDIS)

Number:

**Next of Kin:** Name:       Relationship:

**Phone:**  Home:       Work:       Mobile:

**Permission to leave message:**  home  mobile

**Interpreter required:**   Yes  No **Language spoken:**

**Relevant personal/social issues:**

*Reason for Referral/ Services required:* (Please attach pathology results for all diabetes & CAPAC referrals)

***Medications: Allergies/Topical Sensitivities:***

Please fill in medication order below for all IM, IV and Eye drops medications. A doctor must administer first dose for all IM and IV medications. Dr’s original orders should be given to the client for the Community Nurse. Clients are also required to supply their own medications as ordered. *For all other medications please include a separate list.*

**First dose(s) given by:**       Date:       Time:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Start Date** | **Medication** | **Route** | **Dose** | **Frequency** | **End Date** | **Signature** |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**GP name:**       **Date:**       **Time:**