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ACT Health

Patient Information and Referral Form CHI

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

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Consumer Details:

Title: _____ Given Names: _____ Surname: _____

Usual Address: _____

Phone: H: _____ Mob: _____

Message authorisation: ☐ Home ☐ Mobile ☐ SMS

Service Address and Phone (if different from above):

Address: _____

Phone / Mob: _____

Baby's Details

Name: _____ Gender: ☐ M ☐ F D.O.B.: _____/_____/_____

☐ Next of Kin ☐ Emergency Contact Details ☐ Power of Attorney

Name: _____ Relationship: _____

Phone: H: _____ Mob: _____

Message authorisation: ☐ Home ☐ Mobile

Name: _____ Relationship: _____

Phone: H: _____ Mob: _____

Message authorisation: ☐ Home ☐ Mobile

Demographic Details:

Country of Birth: _____

Interpreter: ☐ Yes ☐ No Language Spoken: _____

Identifies as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Living Arrangements

☐ Alone
☐ Family
☐ Other: _____

Accommodation Setting

☐ Private Own
☐ Private Rental
☐ Public Housing
☐ Other (specify): _____

Funding type (if applicable)

Medicare number: _____
☐ Centrelink Pension
☐ Commonwealth Home Support Program (CHSP)
☐ National Disability Insurance Scheme (NDIS)
☐ Health Care Card
☐ Vets Affairs GOLD
Number: _____
☐ Compensable
Claim No: _____
☐ Commonwealth Home Care Package
Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Medical Practitioner:

GP (name): _____ Phone: _____

Specialist (name): _____ Phone: _____

Alerts / Allergies:

Other Alerts: (Behavioural, Environmental)

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

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Hospital Admission Date: ___/____/____ **Expected Discharge Date:** ___/____/____

Reason for hospital admission / Clinical issue: _____

	Services Requested	Clinical Reason for Services
1.		
2.		
3.		
4.		

Consent from consumer obtained? ☐ Yes ☐ No

Waterlow Risk Assessment Score: ☐ At Risk = 10 ☐ High Risk = 15 ☐ Very High Risk = 20+

☐ **Specific Medical Instructions:** _____

☐ **Additional Documentation Attached**

☐ Treatment Orders ☐ Medical Officer Orders for Medication Administration

☐ Catheter Management ☐ Other: _____

Referrers Details (*please print clearly*):

Referral Agency: _____ Contact Name: _____

Phone/Mobile: _____ Fax: _____

Email: _____

Signature: _____ Date: ____/___/____

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

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Current Relevant Clinical History:

Past Medical History:

Social Details:

Other Services:

Was the consumer receiving any services prior to hospital admission? ☐ Yes ☐ No ☐ N/A
If yes please list services below

Other Services (not provided by ACT Health)	**Agency**

Have referrals been made to other services post discharge? ☐ Yes ☐ No
If yes please list services below

Other Services (not provided by ACT Health)	**Agency**

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