



Complete details or affix label

ACT Health

GP only Referral for CHI

URN: _____

Family name: _____

Given names: _____

DOB: _____ 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: Male Female 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 NDIS

Commonwealth Home Support Program (CHSP) Card 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 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 dd/mm/yy	Medication	Route	Dose	Frequency	End date dd/mm/yy	Signature
dd/mm/yy					dd/mm/yy	
dd/mm/yy					dd/mm/yy	
dd/mm/yy					dd/mm/yy	
dd/mm/yy					dd/mm/yy	

GP Signature: _____ Date: ___/___/___ Time: _____

Referrer details:

Signature _____ Print name _____ Designation _____ Phone number _____

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