ACT Health

GP only Referral for CHI

Complete details or affix label

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: ☐ 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 ☐ 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 & 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 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:** ______

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