



GP REFERRER DETAILS			Date of Referral
Referrer Name			Last Name
GP Practice			
Address			
Phone No.			Email
Fax No.			HealthLink EDI
PATIENT DETAILS			
First Name			Date of Birth
Last Name			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unstated
Address			
Home Phone			Email
Mobile Phone			Consent to referral <input type="checkbox"/> YES <input type="checkbox"/> NO
ELIGIBILITY CRITERIA / REFERRAL REASON			
<p>Patient must satisfy two (2) or more of the following:</p> <p>1) <input type="checkbox"/> Yes, 75+ yrs old and frail. Residing in Hornsby, Ku-ring-gai or Ryde council areas</p> <p>2) <input type="checkbox"/> Yes, living with three or more chronic health conditions/comorbidities.</p> <p>3) <input type="checkbox"/> Yes, would benefit from Care Coordination support to reduce risk of admission to hospital.</p>			
<p>Key Issues Identified (e.g., no current supports at home, no community care supports in place, multiple follow-up appointments need to be organised, home environment may need review, assistive equipment required, etc.)</p>			
ADDITIONAL CLIENT INFORMATION			
Country of birth			Main language spoken at home?
Aboriginal	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>(If needed - tick both)</i>	Communication support required? <input type="checkbox"/> YES <input type="checkbox"/> NO
Torres Strait Islander	<input type="checkbox"/> YES <input type="checkbox"/> NO		(Please provide details)
Employment status	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Benefits, please specify:		
Are there any risk factors we should be aware of when visiting the home/client?	<input type="checkbox"/> NO <input type="checkbox"/> YES - please specify or attach existing risk assessment if available.		
ASSOCIATED DOCUMENTS			
<p>1) <input type="checkbox"/> Yes, I have attached the Patient's Health Summary (if available)</p> <p>2) <input type="checkbox"/> Yes, I have attached the Patient's Care Plan (if available)</p>			
<p>OFFICE USE ONLY Date: <input type="checkbox"/> Accepted <input type="checkbox"/> Referral not accepted, reason:</p>			