Government of South Australia
SA Health

CHSALHN Inc.

Community Health Referral

UR Number:

Family Name:

Given names:

Preferred Name:

Date of Birth: | **Sex:**

Date Of Referral: ____/____/____

Guardianship of the Minister? ☐Y/☐N

Client aware of referral? ☐Y/☐N | **Consent Given?** ☐Y/☐N | **Response required:** ☐Y/☐N

Preferred method of response: Phone / Fax / Email

Form completed by (*print name*):

Phone number: | **Agency:**

Inpatient? Y/N Admission Date: ____/____/____ **Discharge Date: *(if known)*** ____/____/____

Hospital: | **Department / Ward:**

Reason for Admission:

Multiple recent hospital admissions? ☐ **Y /** ☐ **N**

GP: | **CLINIC:**

REASON FOR REFERRAL

FURTHER CLIENT INFORMATION

Residential Address:

Home Phone: **Mobile:**

Medicare Card No: | **DVA:** ☐Y/☐N **Type:**

Please include expiry date and position number for all Medicare / Concession Cards

Concession Type | **Card No:**

Country of Birth: | **Language:**

Indigenous Client? ☐ **Y /** ☐ **N /** ☐ **Unknown** | **Interpreter Required?** ☐Y/☐N

Allergies? ☐Y/☐N | **Infectious Conditions?** ☐Y/☐N | **Alerts / Hazards** ☐Y/☐N

Details of above:

Medical Diagnosis / Health Conditions:

Past Relevant Medical History:

FUNCTIONAL INFORMATION

Mobility:

Transfers:

Personal Care:

Any other relevant information:

CONTACT / NEXT OF KIN / GUARDIAN / CARER: (circle appropriate contact type)

Name: | **Relationship:**

Address:

Home Phone: **Mobile:**

FAX TO: 1800 771 211 **E-mail** Health.CHSACountryReferralUnit@health.sa.gov.au

CHSALHN COMMUNITY HEALTH REFERRAL