Peninsula Health

ACCESS REFERRAL

Fax: 9784 2309
Phone: 1300 665 781
(Internal) Email: 'Access Referrals'
(External website):www.peninsulahealth.org/access-referrals/

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH ..... Gender .....
Please fill in if no Patient Label available

App.31/01/2022 Print Code:12736

PHF151650Y

Address: ..... P/C: ..... Phone: .....

Email: .....

Other Contact Person: ..... Phone: ..... Relationship .....

Preferred contact method: Phone / SMS / email / other .....

Country of Birth: ..... Preferred Language: .....

Aboriginal / Torres Strait Islander: Yes / No / Not Stated Refugee Status? Yes / No Interpreter required? Yes / No

Medicare No. ..... MAC ID. ..... Pension/Health Care/ DVA Gold Card No. .....

Compensable Category: *(please circle)* Workcover / TAC / DVA / Overseas visitor / N/A

GP Name: ..... GP Phone: .....

GP Address: .....

Service Referred to: **Practitioner:** .....

☐ Aboriginal Health Services	☐ Continence	☐ Geriatric Medicine Clinic (GMC)	☐ Podiatry
☐ Advance Care Planning	☐ Counselling	☐ Integrated Pain Service (PHIPS)	☐ Physiotherapy
☐ Agestrong	☐ Children's Services	☐ Lymphoedema	☐ Pulmonary Rehab
☐ Alcohol & other Drugs	☐ Diabetes Education	☐ MI Health (Homelessness)	☐ Sexual Health
☐ Cancer Rehab	☐ Dietetics	☐ Movement Disorder Program	☐ Social Support Group
☐ Cardiac Services	☐ Exercise Physiology	☐ NDIS services	☐ Speech Pathology
☐ Cognition, Dementia & Memory Service (CDAMS)	☐ Falls Prevention	☐ Occupational Therapy	☐ Other .....
☐ Community Care (HARP / RIR / PAC)			

Anticipated Discharge Date: ..... / ..... / .....

Current Inpatient Yes ☐ No ☐ Client is registered with My Aged Care? ☐ Yes ☐ No

Contact should be made with: ☐ Client ☐ Other contact person Clients consent to referral ☐ Yes ☐ No

☐ Home Based ☐ Centre Based ☐ Urgent ☐ Routine

Reason for Referral: .....

.....

.....

Diagnosis / Medical History / Recent Surgery: .....

.....

Communication	**Physical Function**	**Social**	**Current Services**	**Risks**
☐ Hearing impaired	☐ Independent	☐ Lives Alone	☐ Council	☐ Behavioural Concern
☐ Vision impaired	☐ Requires Prompting	☐ Lives with family	☐ NDIS Plan	☐ Allergies
☐ Speech impaired	☐ Requires Assistance	☐ Lives with others	☐ Private Services	☐ Other (list)
☐ Cognitive impairment	☐ Walks with aids	☐ Out of home < 18yrs	☐ Child Protection	.....
☐ Reduced insight	☐ Falls with harm history	☐ Lives in Aged care Fac.	☐ Home care package	.....
☐ Low literacy	☐ Incontinent		☐ Other	.....

Referrer Name: ..... Signature: ..... Desig / Provider No. .....

Organisation Name / Address: .....

Phone: ..... Date: ..... / ..... / .....

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MR/151650

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