Grand Pacific Health

Connecting Care Referral

Referral source information

Name:

Phone number:

Client information

Referral date:

MRN:

Surname:

First name:

Date of birth:

Phone:

Mobile:

Address:

Alternate contact:

Language spoken at home:

Interpreter required?

Reason for referral:

Consent

Does the patient consent to being contacted by Connecting care?

☐ Yes ☐ No

Has the patient consented to the sharing of information?

☐ Yes ☐ No

Family structure

☐ Lives alone
☐ Lives with family
☐ Lives with others
☐ Not stated/inadequetely described

Aboriginality

☐ Aboriginal but not Torres Strait Islander origin
☐ Torres Strait Islander but not Aboriginal origin
☐ Aboriginal and Torres Strait Islander origin
☐ Neither Aboriginal or Torres Strait Islander
☐ Not stated/inadequetely described

OH&S Risk Alert (e.g. history of aggression, violence, mental health issues)

Does the client have any of the following:

☐ Cardiovascular disease
☐ Diabetes
☐ Respiratory disease
☐ Other:
☐ Other:

Tel: 1300 792 755 **Fax:** 4223 8455 **Email:** islhd-accessandreferralcentre@health.nsw.gov.au

Monday to Friday 8.30am - 4.45pm
Weekends and Public Holidays 8.30am - 3.00pm

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Health
Illawarra Shoalhaven
Local Health District

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