BCH Bass Coast Health

Self Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

Date of Birth ... / ... / ... Age .....

Doctor ..... Ward .....

Address .....

PLACE LABEL HERE

Date of Contact / call received: _____ /_____ /_____

PERSONAL DETAILS

Full name _____

Preferred name (if different to above) _____

Home Address _____

Postal address _____

Date of Birth _____ / _____ /_____ Sex at Birth _____

Gender _____ Pronouns _____

Phone numbers: Home_____Mobile_____

Email address _____

Preferred Method of Communication _____

Country of Birth _____

Are you Aboriginal or Torres Strait Islander origin? _____

Refugee status ☐ Yes ☐ No ☐ Unknown

Assistance required with communication ☐ Yes ☐ No Type _____

Need for interpreter services ☐ Yes ☐ No if yes preferred language _____

Living arrangements/social	**Accommodation**	**Carer Details**
☐ Alone	☐ Own home/own rental	☐ No Carer
☐ With Family	☐ Supported accommodation	☐ Co-resident carer
☐ With others	☐ Residential Care	☐ Non-resident carer
☐ Not stated	☐ Short term crisis or transitional housing	☐ Not stated
☐ Socially Isolated	☐ Homeless / none	
☐ Well supported socially	☐ Not stated	

Medicare Number			Exp date	___/___/___
Health Care Card			Exp date	___/___/___
Pension	Type		Number	
Workcover	Yes		Number	
DVA	Yes		Number	
My Aged Care Reg	Yes		Number	
Home Care Package	Yes		Ref Num	
NDIS participant	Yes		Ref Num	
	Start date	___/___/___	End Date	___/___/___

Support Coordinator / Case Manager

Name _____Contact Number _____

Email _____

Billing Details _____

GP DETAILS

GP Name _____

Clinic Name _____ Phone/Fax _____

Do you consent to Bass Coast Health Contacting your GP for further information regarding your referral (if required) ☐ Yes ☐ No

SELF REFERRAL

MR/307

BCH3307

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PLACE LABEL HERE

PRIMARY CONTACT PERSON: Who can be contacted if necessary?

Name _____

Contact Number _____ Relationship _____

REFERRAL DETAILS

Service Requested. Who do you want to see:

☐ Breast Care Nurse	☐ High Risk Foot Clinic	☐ Respiratory/Pulmonary/ Rehabilitation/Heart Failure
☐ Cardiac Rehabilitation	☐ Integrated Chronic Disease Management	☐ Specialist Falls Clinic
☐ Continence Nurse	☐ Nurse Practitioner	☐ Speech Therapist
☐ Counsellor	☐ Occupational Therapist	☐ Social Support Group
☐ Dietician	☐ Podiatrist	☐ Social Worker
☐ Diabetes Education	☐ Physiotherapist	☐ Stomal Therapist
☐ Falls Prevention Program	☐ Physiotherapist/lymphoedema	☐ Urodynamics Nurse
☐ Hand Therapist	☐ Physiotherapist/women's Health	☐ Wound Care Nurse
☐ Healthwise Program		

If the service you require is not listed please contact the Access team on 03 5671 3175 or email access@basscoasthealth.org.au

REASONS FOR REFERRAL

Presenting problem/s _____

_____

Impact of the problem/s _____

_____

Current treatment _____

_____

Medical history / past procedures _____

_____

_____

_____

_____

_____

Concerns re medication management _____

Allergies ☐Yes ☐No Details _____

_____

Have you had a recent hospital admission/s ☐Yes ☐No If yes date of discharge ____/____/____

Falls History _____

Name of referrer (if not Self) _____

If the referrer is not the client, does the client consent to this referral? Include a reasons they cannot consent for themselves ☐Yes ☐No

_____

Phone 5671 3175 /Email access@basscoasthealth.org.au

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