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| http://inside.wh.org.au/departmentsandservices/publicaffairs/PublishingImages/Logos/jpgs/wh_mast_H_cmyk.jpg  **Aboriginal & Torres Strait Islander Outpatient Clinic Referral Form**  **External Referral**  ***Please complete form digitally and send as attachment to:*** [*AboriginalAndTorresStraitIslanderClinic@wh.org.au*](mailto:AboriginalAndTorresStraitIslanderClinic@wh.org.au) | | | ***Please complete form digitally and send as attachment* Hospital UR:** Click here to enter text. **Name:**  Click here to enter text. **Address:** Click here to enter text. **Suburb and post code:** Click here to enter text. **Telephone:** Click here to enter text. **DOB:** Click here to enter text. **Marital Status:** Choose an item. **Gender:** Choose an item. | | |
| **Triage Use Only** | | | **Triaged by:** Choose an item. Click here to enter a date. | | |
| **Diagnosis/Main health condition:** Click here to enter text. **Other factors Affecting Health:** Click here to enter text. | | | | | |
| **Referrers Name:** Click here to enter text. **Position:** Click here to enter text. **Tel:** Click here to enter text.  **Referrers Email Address:** Click here to enter text. **Referring Hospital / Agency / Clinic:** Click here to enter text. | | | | | |
| **GP Name:**  Click here to enter text. **Clinic Name:** Click here to enter text. **Address:**  Click here to enter text. **Tel:**  Click here to enter text. **Fax:**  Click here to enter text. | | | | | |
| **Contact Person/Next of Kin:**  Click here to enter text. **Tel:** Click here to enter text. **Mobile:** Click here to enter text. **Address:** Click here to enter text. | | | **NOK Relationship**  **Female NOK:** Choose an item. **Male NOK:** Choose an item.  **Contact Person for Appointments:** Choose an item. | | |
| **Case Manager (if Relevant):** Click here to enter text. **Tel:** Click here to enter text.  **Agency/Company Name:** Click here to enter text. | | | | | |
| **Interpreter Required**  Yes  No **Language:** Click here to enter text. | | | | | |
| Patient or carer/NOK must consent to referral  **Has the patient consented to this referral:**  Yes No | | | | | |
| Must identify as Aboriginal and/or Torres Strait Islander | | | | | |
| *Please note- we cannot accept patients with acute surgical conditions* **Patient requires 1 or more services from:** | | | | | |
| Cardiology/Heart Failure Service | |  | Endocrinology | |  |
| Nephrology | |  | General Medicine | |  |
| Respiratory | |  | Gastroenterology- must be stable with a diagnosis/no acute changes | |  |
| **Reason for Referral:**  Click here to enter text. | | | | | |
| **Relevant Medical/Surgical History:**  Click here to enter text. Please attach current medication list | | | | | |
| **Social History:**  Click here to enter text. | | | | | |
| **Please attach recent relevant clinical investigation results (please tick all that apply)** Blood test  X-ray  Wound swab/biopsy  Angiogram  Holter Monitor Echo  MRI  Bone scan   Other (state): Click here to enter text. | | | | | |
| **Any special requirements:**  Mobility issues  Cognitive issues  Bariatric  Hearing/Visual Deficit  **Other- please describe in detail:** Click here to enter text. | | | | | |
| **Carer Availability** No Carer  Co-resident carer Non-resident carer | **Carer Relationship** Spouse/Partner Parent Child Child in law Other relative Friend/Neighbor Foster Carer | | **Living Arrangements** Lives alone Lives with family Lives with others Not stated | **Accommodation** Private (own/rent/purchased) Outreach Supported Community Residential Aged Care  Residential Care facility (not aged)  Short term Crisis/Emergency  Other accommodation | |
| **Country of Birth:** Click here to enter text. **Aboriginal or Torres Strait Islander:** Choose an item. **Medicare Number:** Click here to enter text. **Pension Number:** Click here to enter text. **DVA Number (if applicable):**  Click here to enter text. **TAC?**  No  Yes- **Claim Number:** Click here to enter text. **WorkCover?**  No  Yes- **Claim Number:** Click here to enter text. | | | | | |
| **Clerical use only Requested appointment date:** Click here to enter a date. **Time:** Choose an item. **Booked on iPM:** Click here to enter a date. **Time:** Choose an item. **Clerked by:** Click here to enter text. | | | | | |