|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| DOB |  | | | | PID Number | |
| Gender |  | | | |  | |
| Title |  | | | Surname |  | |
| Given Names | | |  | | | |
| Address | |  | | | | |
|  | | | | | | *(Type or affix sticker)* |

|  |  |
| --- | --- |
| **CLIENT DETAILS** | |
| Full Name: | DOB: |
| Address: | |
| Email: | Telephone: |
| Medicare Card (include number/reference/expiry) : | |
| Health Care card (if applicable): | |
| Next of Kin (NOK)/Carer Name: | NOK/Carer Telephone: |
| Aboriginal  Torres Strait Islander  Both Neither | |
| Does the client have a Home Care Package?  Yes  No  HCP Level:  Level 1  Level 2  Level 3  Level 4 | |
| Does the client have NDIS support?  Yes  No | |
| Are there any concerns with the client communicating via telephone  Yes  No | |
| Has client consented to this referral?  Yes  No | |
|  | |
| **REFERRAL DETAILS** | |
| Diagnosis: | |
| Reason for referral: | |
| Relevant Medical History: | |
| Relevant Social History: | |
| Other factors: *(such as hearing impairment, cognition, risk factors)* | |

|  |  |
| --- | --- |
| Clinical supporting documentation enclosed:  *Yes*  *N/A* Discharge/Health Summary  *Yes*  *N/A* Pathology results (HbA1c, FBGL, OGTT, lipids)  *Yes*  *N/A* GP Management Plan | |
| **CURRENT MEDICATIONS (including allergies)** | |
|  | |
| **REFERRER DETAILS** | |
| Referrer Name: | Telephone: |
| Referring Organisation: | Fax: |
| Referrer Provider No. (if applicable): | Date completed: |
| Referrer Email: | |
| Client’s GP (if referrer is not GP): | |

**Please complete and fax individual referral to 1300 601 788**

**or email** [**SCReferrals@silverchain.org.au**](mailto:SCReferrals@silverchain.org.au)