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

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REFERRAL SOURCE** | | | | | | | | | | | |
| Self | Street Doctor | | | Other, *please list*: | | | | | | | |
| **CLIENT DETAILS** | | | | | | | | | | | |
| Client Phone: |  | | | Preferred Name: | | | | |  | | |
| Do you identify as Aboriginal or Torres Strait Islander? | No | | Aboriginal | Torres Strait Islander | | | | | Both Aboriginal and Torres Strait Islander | | |
| Country of Birth: |  | | | Primary Language: | | | | |  | | |
| Interpreter required: | No  Yes, *language required*: | | | | | | | | | | |
| Gender: | Male Female Transgender Non-binary Not specified | | | | | | | | | | |
| Medicare Number: |  | | | | Ref: | | |  | Expiry: | |  |
| Next of Kin: |  | | | Tel: |  | | | | Relationship: | |  |
| Support contact: |  | | | Tel: |  | | | | Relationship: | |  |
| Guardian/Trustee: |  | | | Tel: |  | | | | | | |
| Current living arrangements: | St Pats  Boarding House  Short Term Crisis  Public Housing | | | | | | | | | | |
| Private Rental  Home Owner Street Present  Not disclosed | | | | | | | | | | |
| **MEDICAL AND EXISTING SUPPORTS** | | | | | | | | | | | |
| Treating GP Name: |  | | | Practice | | |  | | | | |
| Email: |  | | | Tel: |  | | | | Fax: |  | |
| Case/Support worker: |  | | | Org: |  | | | | | | |
| Email: |  | | | Tel: |  | | | | Fax: |  | |
| Pharmacy: |  | | | Tel: |  | | | | Fax: |  | |
| **PRESENTING PROBLEM AND MEDICAL PSYCHOSOCIAL HISTORY** | | | | | | | | | | | |
| Presenting Problem: |  | | | | | | | | | | |
| Relevant Medical, Surgical, Psychiatric History: |  | | | | | | | | | | |
| BBV: | | | | | | | | | | |
| Any Known Allergies: | Nil  Yes, *please list:* | | | | | | | | | | |
| Current Medications:  *(include non-prescription)* |  | | | | | | | | | | |
| Drug and Alcohol use: | Unknown  Nil  Yes, *please list:* | | | | | | | | | | |
| Behaviours of Risk: | Unknown  Nil  Yes, *please list:* | | | | | | | | | | |
| Community Treatment Order: | | No  Yes, *with whom*: | | | | | | | | | |
| **TREATMENT REQUEST** | | | | | | | | | | | |
| Assessment | Monitor Vital Signs | | | Health Promotion | | | | | Diabetes Education | | |
| Wound Management | Mental Health  Support | | | Referral – Drug and Alcohol | | | | | Referral – Mental  Health | | |
| Referral – Allied Health | Health Plan Development | | | Clinical Case Management | | | | | Referral to External Agency (PCAH) | | |
| Other |  | | | | | | | | | | |
| **PERSON COMPLETING FORM** | | | | | | | | | | | |
| Print Name: |  | | | | | Date: | | |  | | |
| Signature: |  | | | | | Designation: | | |  | | |