|  |  |  |
| --- | --- | --- |
| 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: |       |