NWRH Referral Form

Fax: 61744220079
Email: referrals@nwrh.com.au

Referral Date:	
Community to be seen in:	

Medicare Services: *Referrals being made under a Medicare Allied Health Initiative, DVA or WorkCover, please attach the relevant Medicare, DVA or WorkCover referral form and a copy of the GP Management Plan, Team Care Arrangements or Mental Health Treatment Plan where relevant.*

Aged Care Services: *Referrals for Aged Care Services need to be completed using the referral form on the My Aged Care Website.*

****Queensland Community Support Scheme:*** *These services are only available for clients not eligible for NDIS or Aged Care*

SERVICES

East Coast (EC) / Central West (CW) / North West (NW) / Lower Gulf (LG)

☐ Aboriginal Health Practitioner (NW)	☐ Family Wellbeing Support (NW, LG)
☐ Carer Support (NW, EC, CW, NW)	☐ In-home/Community Access (NW)*
☐ Child & Youth Mental Health (LG, NW)	☐ Mental Health Nurse (EC)
☐ Community Transport (NW)*	☐ Mental Health Professional/Counselling (NW, LG, EC, CW)
☐ Continence Advisor (CW, EC, NW, LG)	☐ Occupational Therapist (EC, NW, LG, CW)
☐ Dementia Advisor (NW, LG)	☐ Physiotherapist (CW, EC, NW)
☐ Dietitian (CW, NW)	☐ Podiatrist (CW, EC, NW)
☐ Drugs and Alcohol (LG)	☐ Speech Pathologist (NW, LG, CW)
☐ Exercise Physiologist (CW, EC, NW)	Other: _____

CLIENT DETAILS

Full Name		**Gender**	☐ Male ☐ Female ☐ Other
Address		**Ethnicity**	☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Australian South Sea Islander
DOB		**Culturally & Linguistically Diverse (CALD)**	☐ Yes ☐ No
Phone		**Mobile**	
Email			
General Practitioner (GP)		**(GP) Contact Details**	
Known Allergies/Alerts			

NEXT OF KIN / EMERGENCY CONTACT

Name	
Relationship	
Contact Details	

CARER of CLIENT (If applicable)

Name	
Relationship	
Contact Details	

REFERRAL SOURCE

Full Name	
Contact Details	

REASON FOR REFERRAL

Medical Condition/s	
Medication/s	

CLIENT CONSENT

I_____consent to this referral being made, for the creation and maintenance of a file and for the sharing of my personal information with NWRH and other Health care providers for the purpose of actioning this referral.

Client / Parent / Guardian to sign:

Signature: Name: Date:

☐ Verbal Consent obtained