Community and Allied Health Self-Referral Form

PERSONAL DETAILS					
Title		**Given Names**			
Surname			**Gender**		
Date of Birth			**Home phone**		
Email			**Mobile phone**		
Address					
GP DETAILS					
GP's Name		**Clinic**			
Phone number		**Fax**			
Address					
CONSUMER DETAILS					
Country of birth		**Language/s spoken**			
Marital status		**Are you a refugee?**	☐ No ☐ Yes		
Aboriginal or Torres Strait Islander	☐ Aboriginal ☐ Torres Strait Islander ☐ Neither				
Living arrangements	☐ Living alone	**Accommodation**	☐ Independent living		
	☐ Living with family		☐ Supported accommodation		
	☐ Living with others		☐ Hostel / nursing home		
	☐ Has a carer		☐ Homeless		
Medicare number		**IRN**		**Expiry date**	
Health care card		**Expiry date**			
Pension card		**Expiry date**			
DVA number		**Expiry date**			
NDIS number		**My aged care number**			
EMERGENCY CONTACT DETAILS / NEXT OF KIN					
Name					
Relationship		**Phone Number**			
Address					

REFERRAL DETAILS

What service/s are you requesting?

☐ Occupational Therapy	☐ Physiotherapy	☐ Speech Pathology
☐ Dietitian	☐ Cardiopulmonary Rehabilitation	☐ Diabetes Education
☐ Social Work	☐ Alcohol and other Drug Counselling	☐ Exercise Physiology
☐ Mental Health Counselling	☐ Chronic Disease Nursing	☐ Strength Training

Other:

Reason for referral:

Medical history including past procedures:

Medications:

Allergies

☐ No ☐ Yes List:

CONSENT

I am over the age of 18, I am making this referral on behalf of myself, and I consent to this referral

☐ No ☐ Yes Signature:

I am under the age of 18 and my parent/guardian is making this referral on my behalf

☐ No ☐ Yes Signature:

I consent to IDHS contacting my GP for further information regarding my referral

☐ No ☐ Yes

I consent to IDHS accessing relevant medical imaging relating to my referral

☐ No ☐ Yes

I consent to IDHS registering my referral with My Aged Care as necessary

☐ No ☐ Yes

Please complete and return this form to referrals@idhs.vic.gov.au, or to IDHS reception.