HEALTHY ME, HEALTHY COMMUNITY

REFERRAL FORM

WHO IS ELIGIBLE TO PARTICIPATE IN THE SERVICE? | People residing in the Port Macquarie region, seeking increased community connection, experiencing isolation or loneliness, and are aged 18 years or older.

PHONE: 1300 987 215 **FAX:** 1300 850 770 **EMAIL:** hmhc@feroscare.com.au **WEB:** feroscare.com.au/hmhcreferral

REFERRER DETAILS

This section must be completed.

Date: _____

Referring organisation: _____

Referrers name: _____

Referrer role: _____

Organisation address: _____

Contact phone: _____

Contact fax: _____

Contact email: _____

How did you hear of Healthy Me, Healthy Community program?

_____

CLIENT REGULAR GP DETAILS

If different to referrer details.

Regular GP: ◯ **Yes** ◯ **No** ◯ **Unsure**

Regular GP name: _____

Practice name: _____

Practice address: _____

_____

Contact phone: _____

GP visits: ◯ **Rarely** ◯ **Regularly** ◯ **Frequently** ◯ **Unsure**

CLIENT DETAILS *This section must be completed.*

First name: _____ Last name: _____

Gender: _____ Date of birth: _____

Home address: _____

Suburb: _____ Postcode: _____

Postal address if different to above: _____

_____

Phone: _____ Email: _____

Is client of Aboriginal or Torres Strait Islander Origin? ◯ **Aboriginal** ◯ **Torres Straight Islander** ◯ **Both** ◯ **NA**

Preferred language: _____ Is an interpreter required? ◯ **Yes** ◯ **No**

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CONSENT FOR REFERRAL *This section must be completed.*

Is the client aware of this referral and has consent been given?

◯ **Yes they are aware and given consent** ◯ **No**

ADDITIONAL CLIENT INFORMATION *Please remember this is a NON clinical service.*

Does the client have a carer/support person:

◯ **Yes** ◯ **No** ◯ **Unsure**

If yes, please specify: _____

Any barriers to service:

◯ **Yes** ◯ **No** ◯ **Unsure**

If yes, please specify: _____

REASON FOR REFERRAL

Description of presenting or underlying issues:

Any significant history of relevance to this referral:

GP REPORTING *This section must be completed.*

Program progress and final reports to be sent to GP (patient consent required): ◯ **Yes** ◯ **No**

Please fax completed form to Feros Care 1300 850 770 or email hmhc@feroscare.com.au

To learn more please visit feroscare.com.au/hmhcreferral or scan the QR code.

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