Referral cover sheet and acknowledgement

Purpose: to send with a referral or to acknowledge receipt of a referral

Consumer

Name:

Date of Birth:

Sex:

UR Number:

or affix label here

Date:

Referral

To send a referral complete this section

to *Family Services Unit* Position
Njernda Aboriginal Corporation Phone 035480 6252
Fax 035482 1066

From Name
Organisation
Address

Referral for type of service/services requested

Priority: Urgent Non- urgent
SCTT attached
Consumer Information Assessment information/report
Summary and referral information Care plan
Consent to share Other (list):

Acknowledgement

To acknowledge a referral you have received, complete this section

From	Name	Position
	Organisation	Phone
	Email	Fax
To	Name	Position
	Organisation	Phone
	Email	Fax

Date referral received: dd/mm/yyy _____

Status of referral: accepted wait listed rejected (note reason and suggest alternatives)

Estimated date of assessment dd/mm/yyyy _____

Contact person for further information as above New contact (provide in notes)

Notes:

Practitioner signature_____ Number of pages sent _____

Position _____

Contact (Phone/ email)_____

Consumer Information

To collect common demographic and other essential consumer information that can be shared with another agency.

Consumer

Name:

Date of Birth:

Sex:

UR Number:

or affix label here

Consumer Details

Family Name

Given Names:

Preferred Name/s:

Date of Birth:

Is the date of birth estimated? Yes No

Sex: _____ Title: _____

Home Address

Post code:

Postal Address (if different from above)

Post code:

Contact phone number/s Can leave message?
(tick preferred number)

☐ Home: Yes No

☐ Work: Yes No

☐ Mobile: Yes No

☐ Email: Yes No

Are you a carer or care recipient? ☐

Employee/ student status ☐

Comments

Country of Birth: _____

Indigenous Status: _____

Are you of Aboriginal or Torres Strait Islander origin?
Yes No

Refugee status Yes No Not stated/unknown
If yes, year of arrival: _____

Need for Interpreter Services: _____

Preferred Language: _____

Communication Method: _____

General Practitioner

GP Name:

Practice Name:

Address:

Phone:

Fax:

Who the Agency Can Contact if Necessary

(e.g. carer, parent, next of kin, guardian, friend, emergency contact, support worker)

Contact 1 Name:

Address

Post code:

Phone numbers
Home:

Work:

Mobile:

Relationship to Consumer:

Person 2 Name:

Contact Address

Post code:

Phone numbers
Home:

Work:

Mobile:

Relationship to Consumer:

Government Pension/Benefit Status:
if on disability support pension nature of disability

Do you have any other supports such as TAC or Work cover?

Health Care Card Holder Status:
Card number:

Medicare Card:
Card number:

Health Insurance Status:
Insurer name:

Card number:

DVA Card Entitlement:
DVA card type:
DVA card number:

Compensable Funding Source:

Summary and Referral Information

To record and share a summary of the consumer's problems/issues, provide information to indicate eligibility, and an initial action plan when making a referral.

Consumer

Name:

Date of Birth:

Sex:

UR Number:

or affix label here

Presenting Issue(s) as Identified by Consumer:

Reason for Referral:

Description of presenting and underlying issues

Current presentation/episode; presenting problem(s) –

Significant history (medical, medication issues, developmental, functional/daily living skills, emotional, trauma- including abuse or neglect etc.)

Other:

Court and statutory orders:

Mental Health orders:

Orders relating to children:

Intervention orders:

Guardianship and administration orders:

Other type of court or statutory order(please specify)

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This information collected by:		
Name:	Position/Agency:	
Sign:	Date: dd/mm/yyyy / /	Contact number:

Summary and Referral Information

To record and share a summary of the consumer's problems/issues and an initial action plan when making a referral.

Consumer

Name:

Date of Birth:

Sex:

UR Number:

or affix label here

Alerts

Allergies:

Risks; (attach any available assessments)

Risk management strategies:

There are concerns that the consumer is not capable of making their own decisions:

Enduring powers of attorney are in place

Access to the referred service has been discussed with the consumer? Yes No

Barriers to service:_____

Support required to address barrier to service:_____

Current Services

Record services used in the last twelve months. Consider all health and community services.

Agency	Service Type	Record contact details or other information as appropriate

Referrals sent

Agency	Service Type	Contact Details	Purpose of Referral	Feedback to

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This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Consumer Consent to Share Information

To record freely given informed consumer consent to share their information with a specific agency/ies for a specific purpose/s.

Consumer

Name:

Date of Birth:

Sex:

UR Number:

or affix label here

Section 1: Personal/health information to be shared

Service Type	Name of Agency	Type of Information	Purpose/s
Examples: *– Physiotherapy* *– counselling*	*Examples:* *– mytown community health center* *– mytown City Council*	*Examples:* *– All relevant information* *– Exceptions as stated by the consumer*	*Examples:* *– Referral* *– Shared care/case planning* *– Informing services participating in consumers care*

Section 2: Record of Consumer Consent

Written Consumer Consent

I understand this and I give my consent for the information to be shared with other service providers, as above.
Signed:
Date: dd/mm/yyyy

Verbal Consumer Consent

I have discussed with the consumer how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given

or

Consumer does not have the capacity to provide consent

(that is they do not understand the nature of what they are consenting to, or the consequences)

Consent given by authorised representative_____
Name of authorised representative

There is no authorising representative or they were uncontactable, threfore the information will be shared as set out in the Health Records Act 2001*

**If it is not reasonably practical to obtain consent from an authorisd representative or the consumer does not have an authorised representative, health information can be shared in the circumstances set out in the Health Records Act 2001. This includes where the sharing of information is done by a health service provider and is reasonably necessary for the provision of a health service or where there is a statutory requirement*.

To ensure the consumer/consumer's authorised representative is able to make an informed decision about consent to the sharing of information as detailed above, the worker/practitioner should: (tick when completed)

1. Discuss with the consumer the proposed sharing of information with other services/agencies ☐
2. Explain that the consumer's information will only be shared with these services/agencies if the consumer has agreed and, when referring, advise that referral for service can still proceed if the consumer does not want information disclosed ☐
3. Provide the consumer with information about privacy, such as the brochure *'Your Information – It's Private'* ☐
4. Provide the consumer with a copy of this form if requested (see guidelines) once completed ☐

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Consent obtained / witnessed by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number: