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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| allied health referral form | | | | | | | | | | | | | | | |
| Please note: By sending this referral it indicates that the client is aware of the reason of referral, as well as the benefits of attending an Allied Health appointment, and therefore consents for their details to be sent to Boab Health and to be contacted. | | | | | | | | | | | | | | | |
| Patient Name: | | | |  | | | | |  | | | DOB: |  | | |
| TSI  Aboriginal | | | |  | | | | |  | | M M  F  Unknown | | |  | | |
| Parent/Guardian(if applicable): | | | |  | | | | |  | | Relationship: | | |  | | |
| Phone: | |  | Address: | | | | | | | | | | | | |
| Preferred Consult Site: | | | | | | | |  | | | | | | | |
| Medicare #:       / | | | | | Expiry Date:       / | | | | GPMP  TCA  REVIEW | | | | | |  |
| Language Spoken: | | | | |  | English Level: Not at all Not well Well Very well | | | | | | | | |  |
| **Documents Attached:** Relevant Medical History & Allergies  Medications – current meds and instructions  Pathology/Investigations - pls attach latest relevant blood, investigations growth charts etc | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **REFERRAL REASON DETAILS** | | | | | | | | | | | | | | | |
| Dietitian | **Paediatric Nutritionist** | | | | | | **Diabetes Educator** | | | | | **Podiatry** | | | |
| Overweight/Obese  Underweight/Malnutrition  Allergies & Intolerances  Anaemia  Renal  Digestive disorders Other (pls specify) Height:       Weight:  Date Checked: | GDM new diagnosis Anaemia  Allergies & Intolerances  Growth faltering  Obesity in children  Diabetes in children  Other (pls specify)  Height:       Weight:  Date Checked: | | | | | | T1DM  T2DM  GDM Hypoglycaemia  Pre-diabetes  Newly diagnosed  Poorly contolled/high risk  Insulin therapy  Byetta/Bydureon initiation  DESMOND/group interest  Other (pls specify)  HbA1c:       Date:  NDSS Reg?: Yes  No | | | | | Foot ulcer Diabetes foot check  Peripheral vascular  Peripheral neuropathy  Foot deformity  Biomechanical injury  Previous amputation  Ingrown toenail  Other (pls specify)  Foot: Left  Right  Location: | | | |
| Other Comments | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **REFERRER DETAILS** | | | | | | | | | | | | | | | |
| Referrer Name: | | | | | Provider Number: | | | | | Referrer Organisation: | | | | | |
| Referrer Phone: | | | | | Referrer Email: | | | | | | | | | | |
| Referrer Signature:       Date:  I have obtained verbal consent from the client/legal guardian to refer and provide their personal health information to Boab Health Services. | | | | | | | | | | | | | | | |
| Send via MMEx “Boab Health Allied” or email: [reception@boabhealth.com.au](mailto:reception@boabhealth.com.au) or FAX: 91 927 999 | | | | | | | | | | | | | | | |
| Please advise the client that if their condition deteriorates from the time of the referral, they should return to their referrer | | | | | | | | | | | | | | | |