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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 [ ]  RightLocation:       |
| 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 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 |