

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 <input type="checkbox"/> Aboriginal <input type="checkbox"/>		M <input type="checkbox"/> F <input type="checkbox"/> Unknown <input type="checkbox"/>	
Parent/Guardian (if applicable):		Relationship:	
Phone:	Address:		
Preferred Consult Site:			
Medicare #:	/	Expiry Date:	/ <input type="checkbox"/> GPMP <input type="checkbox"/> TCA <input type="checkbox"/> REVIEW
Language Spoken:	English Level: <input type="checkbox"/> Not at all <input type="checkbox"/> Not well <input type="checkbox"/> Well <input type="checkbox"/> Very well		
Documents Attached: <input type="checkbox"/> Relevant Medical History & Allergies <input type="checkbox"/> Medications – current meds and instructions <input type="checkbox"/> Pathology/Investigations - pls attach latest relevant blood, investigations growth charts etc			

REFERRAL REASON DETAILS			
<input type="checkbox"/> Dietitian <input type="checkbox"/> Overweight/Obese <input type="checkbox"/> Underweight/Malnutrition <input type="checkbox"/> Allergies & Intolerances <input type="checkbox"/> Anaemia <input type="checkbox"/> Renal <input type="checkbox"/> Digestive disorders <input type="checkbox"/> Other (pls specify) Height: Weight: Date Checked:	<input type="checkbox"/> Paediatric Nutritionist <input type="checkbox"/> GDM new diagnosis <input type="checkbox"/> Anaemia <input type="checkbox"/> Allergies & Intolerances <input type="checkbox"/> Growth faltering <input type="checkbox"/> Obesity in children <input type="checkbox"/> Diabetes in children <input type="checkbox"/> Other (pls specify) Height: Weight: Date Checked:	<input type="checkbox"/> Diabetes Educator <input type="checkbox"/> T1DM <input type="checkbox"/> T2DM <input type="checkbox"/> GDM <input type="checkbox"/> Hypoglycaemia <input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Newly diagnosed <input type="checkbox"/> Poorly controlled/high risk <input type="checkbox"/> Insulin therapy <input type="checkbox"/> Byetta/Bydureon initiation <input type="checkbox"/> DESMOND/group interest <input type="checkbox"/> Other (pls specify) HbA1c: Date: NDSS Reg?: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Podiatry <input type="checkbox"/> Current Foot ulcer <input type="checkbox"/> Infection <input type="checkbox"/> Charcot/neuroarthropathic joint <input type="checkbox"/> Infected ingrown toenail <input type="checkbox"/> Diabetes <input type="checkbox"/> Dialysis <input type="checkbox"/> Hansen's Disease <input type="checkbox"/> Previous amputation <input type="checkbox"/> Peripheral vascular <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Significant foot deformity Foot: <input type="checkbox"/> Left <input type="checkbox"/> 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 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