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|  HEALTH NAVIGATOR 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 the Navigator appointment, and therefore is willing & 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/time arrangement :       |
| 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 [ ]  **Discharge summary attached** & sent to:      Discharge date:        |
|  |
| **REFERRAL REASON DETAILS** |
| [ ] Chronic Condition  | [ ] **Medication Support**  | [ ] **Linking with service** | [ ] **Self-monitoring**  |
| [ ] Diabetes poorly controlled/high risk/newly diagnosed [ ] T1DM [ ] T2DM [ ]  GDM [ ] Diabetic foot ulcer [ ] CVD/peripheral disease [ ] Renal[ ] Anaemia [ ] Digestive disorder [ ] Liver disease[ ] Respiratory Disease [ ] Other (pls specify)     NDSS registered  [ ] YES [ ] NO | [ ] Dossett box [ ] Webster pack [ ] Insulin therapy [ ] Accessing/taking meds. [ ] sick day education [ ] commenced on new medication [ ] Byetta/Bydureon initiation[ ] Other (pls specify)      | [ ] AMS[ ] GP services[ ] healthy lifestyle group [ ] Telehealth [ ] ITC (integrated team care) [ ] Dressing clinic [ ] Allied Health [ ] DESMOND/group interest[ ] Quit skills- smoking  [ ] Specialist appointments [ ] Mental Health/social worker [ ] Silver chain [ ]  Environmental referral [ ] Other (pls specify)       | [ ] Current wound dressing [ ] BSL [ ] Infection [ ] Healthy lifestyle [ ] Blood pressure [ ] Attending dialysis Other:       |
| 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 |