|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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](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 | | | | | | | | | | | | | | |