Allied Health Referral Form

Boab Health Services

Send referral to: Email: reception@boabhealth.com.au **| Fax:** 9192 7999 **| MMEx:** "Boab Health Allied"

*** Please ensure client is informed about reason for referral, benefits of attending & has given consent to sharing their personal details.**

Client name:		**DOB:**	
Is client of ATSI origin? ☐ No ☐ Yes (please circle): Aboriginal / TSI / both		**Gender:** ☐ F ☐ M ☐ Self-described ☐ Unknown	
Parent / Guardian name (if applicable):		**Relationship to child:**	
Mobile:	**Tel** (other)**:**	**Email:**	
Address (street)**:**		**Postal / PO Box:**	
Town:	**State:**	**Post code:**	
Medicare No.: ☐☐☐☐☐☐☐☐☐☐ ☐ (ref. no.)	**Exp. Date:** ☐☐ / 20☐☐	**Please select if the client has the following:** ☐ GPMP ☐ TCA ☐ MBS AH Referral Form	
Main language spoken (if other than English)**:**		**Is an interpreting service required?** ☐ Yes ☐ No	
Preferred consult site (e.g. community, town, AMS etc.)**:**		☐**Group Education** ☐ **Individual consult**	

Is client able to attend a virtual appointment?
Please select one of the following options:
☐ Yes, client has access to a smart phone / laptop / tablet / etc. at **home**.
☐ Yes, client will need to attend their local **health clinic** to access virtual services.
☐ No, client does not consent to a virtual appointment.

Does the client require a support person to attend their appt.? ☐ No ☐ Yes - please provide support person contact details below.
Name: **Tel:**

CHSP / HSP ONLY: Indicate no. of services by intervention type for the next 12 months:
☐No. **Brief** appts. (30mins): _____ ☐No. **Complex** appts. (60 mins): _____

Purchase Order No:

Discipline & Reason for referral (tick all that apply). *Note, the more information you provide here, the more helpful to our clinicians & clients.*

☐ **Dietitian**	☐ **Paediatric Dietitian**	☐ **Diabetes Educator**	☐ **Podiatry:** high risk service
☐ T1DM ☐ T2DM ☐ Overweight/Obese ☐ Underweight/Malnutrition ☐ Allergies & Intolerances ☐ Anaemia ☐ CKD 1-4 ☐ Dialysis ☐ Digestive disorders ☐ Dyslipidaemia ☐ Other (pls specify): Height: Weight: Date Checked:	☐ GDM new diagnosis ☐ Anaemia ☐ Allergies & Intolerances ☐ Growth faltering ☐ Obesity in children ☐ Diabetes in children ☐ Group education ☐ Other (pls specify): ** Pls include copy **child growth charts*** Height: Weight: Date Checked:	☐ T1DM ☐ T2DM ☐ GDM OGTT: FBGL____1 Hr____ 2 Hr____ G__P__& EDD __/__/__ ☐ Impaired glucose tolerance ☐ Newly commenced on insulin ☐ pancreatogenic diabetes ☐ GLP1 medication ☐ Diabetes in children ☐ Continuous Glucose Monitoring System (CGMS) ☐ Other (pls specify): **HbA1c**: Date: NDSS Registered: ☐ Yes ☐ No	☐ Current Foot ulcer ☐ Charcot/neuroarthropathic joint ☐ Infected ingrown toenail with acute signs of infection ☐ Diabetes ☐ End stage renal disease ☐ Hansen's disease ☐ Previous amputation ☐ Peripheral vascular disease ☐ Peripheral neuropathy

Please provide any additional information:

Tick & attach relevant client records included with this referral (required for accurate triage & treatment):
☐ Relevant medical history & allergies ☐ Current medications including dosage
☐ Pathology / investigations i.e. relevant bloods, HBA1c, investigations, child growth charts etc.

☐ **I have obtained verbal consent from the client / legal guardian to provide their personal health information, & refer them to Boab Health Services.**

Referrer details

Referrer Name:	**Provider No:**	**Phone:**
Organisation:	**Email:**	
Signature:		**Date:**