Allied Health Referral Form

Boab Health Services

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

*** Please inform the client the reason for referral & benefits for attending their allied health appointment**

☐MR ☐MRS ☐Miss ☐Master ☐ MS	**First name:** **Surname:**	**DOB:**
☐ **Aboriginal origin only** ☐ **Aboriginal & Torres Strait Islander** ☐ **Torres Strait Islander origin only** ☐ **Unknown Indigenous status**		**Gender:** ☐ F ☐ M ☐ Self-described ☐Unknown
Mobile:	**Tel** (other)**:**	**Email:**
Address (House number/street)**:**		**Postal / PO Box:**
Town/community:		**Post code:** **State:**
Medicare No.: ☐☐☐☐☐☐☐☐☐☐ ☐ (ref. no.) **Exp. Date:** ☐☐ **/ 20** ☐☐		**Client has the following:** ☐ GPMP ☐ TCA ☐ NDIA
Main language spoken (if other than English)**:**		**Is an interpreting service required?** ☐ Yes ☐ No
Client wiling to have virtual appointment? ☐ Yes, client has access to a smart phone / laptop / tablet?		**Clients support person:** ☐ Yes support person contact details: **Name:** **Tel:**
☐ **Group Education** ☐ **Individual consult**		
Parent / Guardian name:		**Relationship to child:**
CHSP / HCP 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/cultural considerations:

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 consent from the client / legal guardian to provide their personal health information to Boab Health Services.**

Referrer details

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