Allied Health Referral Form

Please inform the client the reason for the referral and the benefits for attending their Allied Health appointment

Once complete, send this referral and all accompanying documents to one of the following:

reception@boabhealth.com.au | MMEx Secure Messaging: **Boab Health Allied** | Health Link EDI: **boabheal** | Fax: **08 9192 7999**

CLIENT DETAILS

Date of Referral	**Title**	**First Name**	**Middle Name(s)**

Surname	**Preferred Name**	**Date of Birth**

Sex: ☐ Male ☐ Female ☐ Other | **Gender:** ☐ Male ☐ Female ☐ Non-binary

Is the client of Aboriginal and / or Torres Strait Islander origin?

☐ Aboriginal Only ☐ Torres Strait Islander only ☐ Both Aboriginal and Torres Strait Islander ☐ Neither ☐ Not stated

Country of Birth	**Interpreter Required?**	**Main Language Spoken At Home**
☐ Aus ☐ Other	☐ Yes ☐ No	☐ English ☐ Other

Complete the client's contact detail and choose their preferred method of communication

☐ **Mobile**	☐ **Email**	☐ **Telephone**

Residential Address	**Suburb / Community**	**State**	**Postcode**

Postal Address (If different from above) PO Box, Parcel locker	**Suburb / Community**	**State**	**Postcode**

Healthcare Card ☐ Yes ☐ No | **NDIS Participant** ☐ Yes ☐ No

Medicare card number ☐☐☐☐☐☐☐☐☐☐ **Ref No.** ☐ **Expiry** ☐☐ / ☐☐☐☐

Maritial Status: ☐ Married / Defacto ☐ Divorced / Seperated ☐ Single ☐ Never Married ☐ Widowed

Employment Status: ☐ Full Time ☐ Part-time ☐ Unemployed ☐ Not in the work force

Accomodation Status: ☐ Own house / rental ☐ Short-term / emergency ☐ Staying with friends / family ☐ Homeless

Under 18 Client: *Parent or Guardian / Carer / Emergency Contact*

Name	**Contact Number**	**Relationship to client**

REFERRAL SOURCE

Name	**Phone**

Role	**Email**

Organisation	**Address**

REASON FOR REFERRAL

Please select the following services(s). For information on program eligibility and prioritisation criteria visit our website

☐ **Dietetics**	Dietetic and nutrition support for all ages
☐ **Diabetes Education**	Diabetes Education to support clients to self-manage all types of diabetes
☐ **Podiatry**	Podiatry services for clients with diabetes or other chronic conditions that places them at high risk of foot complications.
☐ **Exercise Physiology**	Support for Aboriginal and Torres Strait Islander clients to increase activity levels and manage chronic conditions or pain. Is it safe for this individual to participate in light-moderate intensity exercise? ☐ Yes ☐ No
☐ **Care Coordination**	Care Coordination to support adult clients with a chronic condition as part of their Allied Health referral. Please tick this box for care coordination support for any client with a GPMP

Further Information

Does the client have a GPMP and / or a chronic disease plan (CDP)? ☐ Yes ☐ No

What is the client's **PRIMARY** chronic condition in relation to this referral (select one only)
☐ Cardiovascular ☐ Diabetes ☐ Chronic Kidney Disease ☐ Obesity ☐ Respiratory ☐ Other

Please indicate any **ADDITIONAL** chronic conditions (select all that apply)
☐ Cardiovascular ☐ Diabetes ☐ Chronic Kidney Disease ☐ Obesity ☐ Respiratory ☐ Other

Relevant medical history (e.g medications, dosage etc).

Any additional information that you feel is relevant to this referral:

To complete this referral please confirm the below:

☐ I have Include all relevant medical history, medications (inc dosage), allergies, pathology (e.g HbA1c, bloods), child growth charts etc to ensure the safe, accurate triage, and care for the client.

☐ I have obtained consent from the client / legal guardian for the referral and they have agreed to provide their personal health information to Boab Health Services.