

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 Aus Other	Interpreter Required? Yes No		Main Language Spoken At Home 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	/
Marital Status:	Married / Defacto	Divorced / Separated	Single	Never Married Widowed
Employment Status:	Full Time	Part-time	Unemployed	Not in the work force
Accommodation 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:

<p>To complete this referral please confirm the below:</p> <p>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.</p> <p>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.</p>
