

EK - 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
☐	
☐	☐ ☐
☐	

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.
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