Queensland Government

Metro North Hospital & Health Service
Aboriginal and Torres Strait Islander Health Unit

Indigenous Acute & Primary Care Team Referral

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F

Client Consent

☐ Yes ☐ No Reason if No Date of Referral

Client Details

Title Name Sex ☐ M ☐ F Date of Birth

Address Phone

Indigenous Status

Does the client require assistance to communicate? ☐ Yes ☐ No ☐ Unknown

Does the client require an interpreter ☐ Yes ☐ No ☐ Unknown

If yes language spoken

Medicare No Expiry Date

Government Benefit Card No

Health Insurance Card No Company

Emergency Contact Details

Name Address

Telephone Relationship to client

Does the client have an EPOA ☐ Yes ☐ No EPOA Name Phone

GP Details (if GP details are same as Referrer, please write "As below" in Practice)

Practice Name

Phone Fax Email

Indigenous Acute & Primary Care Team (Adults) (tick all that apply)

☐ General Assessment ☐ Client Care Coordination / Home Visit

Reason for referral/ client Issues/ Relevant health Condition

Any other information or cultural issues

Referrer Details

Name Address/Agency/Practice

Phone Fax Email

REFERRAL SUBMISSION

Enquiries: 1300 658 252 Fax: 3139 6522 or 3049 1260

DO NOT WRITE IN THIS BINDING MARGIN

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Aboriginal and Torres Strait Islander Health Unit